



# **The Standard Operating Procedure for States' Role in the Payment Error Rate Measurement (PERM) Program**

*August 3, 2015*

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## Glossary

**Active fraud investigation:** A beneficiary or a provider that has been referred to the State Medicaid Fraud Control Unit or similar Federal or State investigative entity including a federal oversight agency and the unit is currently actively pursuing an investigation to determine whether the beneficiary or the provider committed health care fraud. This definition applies to both claims and eligibility.

**Adjudicated claim:** An adjudicated claim is one that has been accepted and reviewed by the claim processing system and a final decision to pay or to deny the claim has been made. Therefore, an adjudicated claim can be either a paid claim or a denied one.

**Adjustment:** An adjustment refers to a change to a previously submitted claim. Typically, an adjusted claim can be linked to the original claim.

**Agency Financial Report (AFR):** Annual report published by the Department of Health and Human Services which provides fiscal and high-level performance results of agency activities, including Medicaid and CHIP payment error rates.

**Annual sample size:** The number of fee-for-service claims or lines or managed care payments necessary to meet precision requirements in a given PERM cycle.

**Capitation:** A previously determined (fixed) payment, usually made on a monthly basis, for each beneficiary enrolled in a managed care plan or for each beneficiary eligible for a specific service or set of services.

**Children's Health Insurance Program (CHIP):** A program authorized and funded under Title XXI of the Social Security Act. Federal regulations governing this program are at 42 CFR Part 457.

**Claim:** A request for payment, on either an approved form or electronic media, for services rendered generally relating to the care and treatment of a disease or injury or for preventative care. A claim may consist of one or several line items or services.

**Claims sampling unit:** The sampling unit for each sample is an individually priced service (e.g., a physician office visit, a hospital stay, a month of enrollment in a managed care plan or a monthly Medicare premium). Depending on the universe (e.g., fee-for-service or managed care), the sampling unit includes claim, line item, premium payment, or capitation payment.

**Continued processing:** Continued processing occurs when a claim did not have the time to go through the full PERM process before the cycle cut-off date. These claims may complete the PERM process through continued processing and CMS will recalculate a State's error rate based on the continued processing results.

**Corrective Action Plan (CAP):** Following each measurement cycle, each state included in the measurement is required to complete and submit a CAP based on the errors found during the PERM process. The CAP process involves analyzing findings from the PERM measurement, identifying root causes of errors, and developing corrective actions designed to reduce major error causes, trends in errors, or other vulnerabilities for purposes of reducing improper payments.

**Cycle:** The 17-state three-year rotation based on Fiscal Year (FY) used to measure improper payments.

**Cycle cut-off date:** This is the last date of the PERM cycle by which information from the states/providers must be received by the Review Contractor (RC). Documentation received or difference resolution/appeals requested after the cycle cut-off date are not included in the national error rate calculations. However, these instances may be eligible for continued processing. Typically, the cycle cut-off date is the second July 15 of a measurement cycle. However, the cycle manager may push back the cycle cut-off date depending on the progress of the cycle.

**Cycle rate:** The improper payment rate for the 17 states measured in the current FY's cycle.

**Cycle summary report:** Cycle summary reports provide official notification of cycle findings and error rates. These reports are typically released around November 15th the year after the fiscal year under review. Each state receives two reports, one for Medicaid, and the other for CHIP. The cycle summary reports contain detailed data analysis of the state's Medicaid and CHIP error findings. The states can use these reports to further analyze the results of the PERM cycle for each component. The reports can also be used as the basis for each state's approach to their corrective action plans.

**Data processing error:** A payment error that can be determined from the information available from the claim or from other information available in the state Medicaid/CHIP claims processing system (exclusive of medical records).

**Data Processing (DP) reviews:** Conducted on each sampled fee-for-service and managed care payment to validate that the claim or payment was processed correctly based on information found in the state's claim processing system and other supporting documentation maintained by the state.

**Deficiencies:** A technical deficiency is a review finding where a problem existed with the claim or medical record but did not affect payment. These are \$0 errors and have no impact on the error rate.

**Denied claim or line:** A claim or line item that has been accepted by the claims processing or payment system, adjudicated, but was not approved for payment.

**Difference resolution:** A process that allows states to dispute the RC's error findings.

**Error rate notification:** Provides to states official notification of their results. Each state receives two notifications, one for Medicaid, and the other for CHIP. The notification reports give the state's error rates for fee-for-service and managed care along with the year's sample size for each of these components. The overall error rate and sample size are also provided. Along with the current year's results, the projected sample size for the state in the next PERM cycle, and target error rates for the next cycle are also included. Both the projected sample sizes and target error rates are based on the current component (Medicaid or CHIP) and the overall error rates of the state.

**Fee-for-service (FFS):** A traditional method of paying for medical services under which providers are paid for each service rendered.

**Final Errors for Recovery (FEFR) report:** Reports that are generated throughout a PERM cycle and include overpayments on claims that have undergone both a data processing and medical review (when required) and all difference resolution/appeals timeframes have expired.

**Improper payment:** An improper payment under IPERIA of 2012 is any payment that has been made to the wrong entity, in the wrong amount or for the wrong reason.

**Managed care:** A system where the state contracts with health plans, on a prospective full-risk or partial-risk basis, to deliver health services through a specified network of doctors and hospitals. The health plan is then responsible for reimbursing providers for specific services delivered.

**Medicaid:** A joint federal and state program, authorized under Title XIX of the Social Security Act that provides medical care to people with low incomes and limited resources.

**Medical review error:** An error that is determined from a review of the medical documentation in conjunction with federal regulations, state medical policies, and information presented on the claim.

**Overpayment:** Overpayments occur when Medicaid or CHIP pays more than the amount the provider was entitled to receive based on existing policy and contracts.

**Partial error:** Partial errors are those that affect only a portion of the payment on a claim.

**Payment:** Any payment to a provider, insurer, or managed care organization for a Medicaid or CHIP beneficiary for which there is Medicaid or CHIP federal financial participation. It may also mean a direct payment to a Medicaid or CHIP beneficiary in limited circumstances permitted by CMS regulations or policy.

**Payment error rate:** An annual estimate of improper payments made under Medicaid and CHIP equal to the total of the overpayments and underpayments in the sample, that is, the absolute value of such payments, expressed as a percentage of total payments made in the sample.

**PERM Website:** The official CMS website for the PERM program located at <http://www.cms.gov/PERM>.

**PERM Plus:** A claims and payment data submission method where the state submits claims, provider, and beneficiary data to the Statistical Contractor (SC). The SC uses the data to build sampling universes from which a sample of claims is selected. After selecting the samples, the SC sends the samples to the RC and the states. The SC then populates the sampled FFS claims with detailed service, payment, provider, and beneficiary information and sends these samples to the RC to facilitate the RC requesting medical records.

**PERM Technical Advisory Group (TAG):** A forum established to discuss technical and operational issues and to share best practices relating to the PERM Program. The TAG is composed of a combination of the Division of Error Rate Measurement (DERM) Director, the PERM team, state Medicaid Directors, CHIP Directors, and state personnel such as managers, supervisors, and program integrity directors.

**Provider Education PERM Initiative (PEPI):** CMS established the PEPI in an effort to support the CAP process and to assist the states in addressing provider education gaps and issues.

**Review Contractor (RC):** CMS contractor responsible for collecting state policies and medical records, conducting data processing and medical reviews, hosting and maintaining the State

Medicaid Error Rate Findings (SMERF) system and assisting with preparation of states' Cycle Summary Reports and the Final PERM Report.

**Rolling rate:** The official Medicaid and CHIP program error rates that include findings from the most recent three cycles to reflect findings from all 50 states and the District of Columbia. Each time a group of 17 states is measured under PERM, the previous findings for that group of states are dropped from the calculation and the newest findings are included.

**Sampling Unit Disposition (SUD) reports:** Reports that are generated on the 15th and 30th of each month during the review phase of the Cycle which include review results.

**State Medicaid Error Rate Findings (SMERF):** A web based application hosted by the Review Contractor used for tracking and reporting the sampling unit review findings for the PERM program.

**State Systems Workgroup (SSWG):** A collaborative group made up of CMS, the PERM Statistical Contractor (SC), the PERM Review Contractor (RC), the Regional Offices, and the states to address state system issues. This group works together to determine the underlying problems and discuss how the issues can be resolved.

**Statistical Contractor (SC):** Collects and samples fee-for-service claims and managed care capitation payment data, and calculate state and national error rates.

**Underpayment:** Underpayments occur when the state pays less than the amount the provider was entitled to receive based on existing policy and contracts.

**Zero-paid claim or line:** A claim or line that has been accepted by the claims processing or payment system, adjudicated and approved for payment, but for which the actual amount remitted was zero dollars. This can occur due to third-party liability, application of deductibles and patient liability, or other causes.



## Introduction

### Purpose

The purpose of this Standard Operating Procedure (SOP) is to provide direction and consistent instructions regarding states' responsibilities during the Payment Error Rate Measurement (PERM) process to state personnel. This SOP serves as a reference guide for the purpose of PERM; it is meant to clarify the roles, responsibilities, and processes that will be followed to ensure that critical tasks are performed timely and accurately. Each state's specific PERM requirements are addressed in more detail in subsequent sections of this SOP.

### Overview of PERM Process

The purpose of the PERM program is to produce a national-level error rate for Medicaid and the Children's Health Insurance Program (CHIP) in order to comply with the requirements of the Improper Payments Elimination and Recovery Improvement Act (IPERIA).

The PERM program estimates improper payment rates for Medicaid and CHIP programs. These rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the federal fiscal year (FY) under review. It is important to note that the PERM error rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory, or administrative requirements. Further note that eligibility review will not be conducted in the FY 2016 cycle.

The FFS and managed care components of Medicaid and CHIP are measured by federal contractors on behalf of CMS. The programs are measured using a three-year rotation to produce and report national Medicaid and CHIP error rates. Each PERM cycle examines the Medicaid and CHIP programs of 17 states. All payment error rate calculations are based on the ratio of projected dollars of improper payments to the dollars of total payments. Individual state error rates for each component (FFS and managed care) are combined to estimate the national component error rates. The national component error rates within a program are then combined to make the national program error rate. The national error rate is termed the national rolling rate since the latest individual state projected improper payments and total payments from all 50 states and the District of Columbia are included in the calculation. The national rolling rate includes results from all three cycles to ensure that each state is represented in the estimation. Since eligibility review is on hold in FY 2016, the national rolling error rate will contain the frozen eligibility error rate from the states' most recent PERM cycle that included eligibility measurement. The state-specific error rates will be comprised of state Medicaid and CHIP claims error rates.

Each PERM cycle begins with a pre-cycle in August of the fiscal year preceding the study year and concludes 28 months later when the error rates are calculated and published in the Agency Financial Report (AFR).

#### Exhibit 1: Medicaid and CHIP Measurement Cycles

Cycle	Includes Payments from These Fiscal Years	States
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Cycle	Includes Payments from These Fiscal Years	States
<b>One</b>	FY 2006 FY 2009 FY 2012 FY 2015	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
<b>Two</b>	FY 2007 FY 2010 FY 2013 FY 2016	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
<b>Three</b>	FY 2008 FY 2011 FY 2014 FY 2017	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington

## Typical PERM Cycle Timeline

### Pre-Cycle: Preparation for Data Submission

- ▶ August
  - Kick-off call with all states in the cycle
  - Each state completes the Universe Data Submission Survey
  - State-specific FFS and managed care sample sizes and sampling plans are shared with each state
- ▶ September – November:
  - Claims Data Submission Instructions are released to the states in September
  - By September 15<sup>th</sup>, the state must notify CMS if it intends to submit claims data using PERM Plus submission mechanism
  - State participates in PERM General Education webinars
  - Statistical Contractor (SC) conducts claims data submission orientation (Intake Meeting) with each state. This meeting involves an in-depth discussion of how claims are processed for the state Medicaid and CHIP programs; payment methodology of broad types of service including managed care, FFS and aggregate payments; data sources and administering agencies; and waiver programs. This review will help the state to build sampling universes or submit PERM+ data meeting PERM specifications, and will allow the PERM SC to become knowledgeable about the state claims processing systems so samples can be selected from the submitted data.
  - State must notify CMS if a Data Use Agreement will be required to transmit data to PERM contractors
- ▶ December
  - State prepares to provide PERM universes or PERM Plus datasets to the SC in January

- States are encouraged to submit a few weeks' PERM universe or PERM+ data as test data to the SC to ensure that the data meet preliminary requirements
- State should discuss with the SC any clarification questions it may have regarding the data submission

**Exhibit 2: PERM Cycle Estimated Timeline**

Timeframe	Event
<b>January 15</b>	<ul style="list-style-type: none"> <li>▪ Routine PERM state submits Q1 (October – December) PERM-compliant claims universes to the SC</li> <li>▪ PERM+ state submits Q1 (October – December) “raw” claims, beneficiary, and provider data to the SC</li> </ul>
<b>January – April</b>	<ul style="list-style-type: none"> <li>▪ State responds to the SC's data and program-specific questions to help the SC to resolve any issues that may be identified with the Q1 PERM submission</li> <li>▪ PERM Plus state provides guidance to the SC to build PERM universes</li> <li>▪ State approves the proposed FFS sample stratification strategy</li> <li>▪ SC selects a sample from each of the Q1 universes</li> </ul>
<b>Within 2 weeks of sample selection</b>	<ul style="list-style-type: none"> <li>▪ Routine PERM state submits Q1 PERM details data to the SC</li> <li>▪ SC creates Q1 details files for PERM Plus state</li> </ul>
<b>April 15</b>	<ul style="list-style-type: none"> <li>▪ Routine PERM state submits Q2 (January – April) PERM-compliant claims universes to the SC</li> <li>▪ PERM Plus state submits Q2 (January – April) “raw” claims, beneficiary and provider data to the SC</li> </ul>
<b>April – June</b>	<ul style="list-style-type: none"> <li>▪ State responds to the SC's data and program-specific questions to help the SC to resolve any issues that may be identified with the Q2 PERM submission</li> <li>▪ SC selects a sample from each of the Q2 universes</li> </ul>
<b>Within 2 weeks of sample selection</b>	<ul style="list-style-type: none"> <li>▪ Routine PERM state submits Q2 PERM details data to the SC</li> <li>▪ SC creates Q2 details files for PERM Plus states</li> </ul>
<b>April – December</b>	<ul style="list-style-type: none"> <li>▪ State assists the Review Contractor (RC) to establish and conduct data processing review orientation visits and on-site or remote data processing reviews</li> </ul>
<b>March – August</b>	<ul style="list-style-type: none"> <li>▪ RC researches and obtains state's policies from relevant web sites and conducts general education webinars with states</li> </ul>
<b>July</b>	<ul style="list-style-type: none"> <li>▪ RC begins data processing reviews at the state or remotely</li> </ul>
<b>July 15</b>	<ul style="list-style-type: none"> <li>▪ Routine PERM state submits Q3 (May – June) PERM-compliant claims universes to the SC</li> <li>▪ PERM+ state submits Q3 (May – June) “raw” claims, beneficiary and provider data to the SC</li> </ul>
<b>July – September</b>	<ul style="list-style-type: none"> <li>▪ State responds to the SC's data and program-specific questions to help the SC to resolve any issues that may be identified with the Q3 PERM submission</li> <li>▪ SC selects a sample from each of the Q3 universes</li> </ul>
<b>Within 2 weeks of sample selection</b>	<ul style="list-style-type: none"> <li>▪ Routine PERM state submits Q3 PERM details data to the SC</li> </ul>

Timeframe	Event
<b>selection</b>	<ul style="list-style-type: none"> <li>SC creates Q3 details files for PERM Plus states</li> </ul>
<b>May – June</b>	<ul style="list-style-type: none"> <li>State assists the RC to establish and conduct SMERF web site orientations/training via conference call/webinar</li> </ul>
<b>September</b>	<ul style="list-style-type: none"> <li>RC begins medical reviews</li> <li>Medical reviews continue for the remainder of the cycle as medical records are submitted by providers</li> </ul>
<b>October 15</b>	<ul style="list-style-type: none"> <li>Routine PERM state submits Q4 (July – September) PERM-compliant claims universes to the SC</li> <li>PERM+ state submits Q4 (July – September) “raw” claims, beneficiary and provider data to the SC</li> </ul>
<b>October – December</b>	<ul style="list-style-type: none"> <li>State responds to the SC’s data and program-specific questions to help the SC to resolve any issues that may be identified with the Q4 PERM submission</li> <li>SC selects a sample from each of the Q4 universes</li> </ul>
<b>Within 2 weeks of sample selection</b>	<ul style="list-style-type: none"> <li>Routine PERM state submits Q4 PERM details data to the SC</li> <li>SC creates Q4 details files for PERM Plus states</li> </ul>
<b>July 15 (of the following year)</b>	<ul style="list-style-type: none"> <li>Typical CMS cycle cut-off date</li> </ul>
<b>September (of the following year)</b>	<ul style="list-style-type: none"> <li>RC submits final findings to the SC</li> <li>SC calculates error rates</li> </ul>
<b>November (of the following year)</b>	<ul style="list-style-type: none"> <li>National rates published in the Agency Financial Report</li> <li>State notified of state error rates and preliminary sample sizes for the following cycle</li> </ul>
<b>Throughout PERM process</b>	<ul style="list-style-type: none"> <li>State assists the SC and the RC with clarification about the universe, samples, and details</li> <li>State identifies and resolves differences in review findings with the RC</li> </ul>
<b>November through February (of the following year)</b>	<ul style="list-style-type: none"> <li>The CAP is due 90 days after the state-specific error rates are issued</li> </ul>

## PERM Partners Roles and Responsibilities

### CMS

- ▶ **CMS Cycle Manager** – A Cycle Manager is assigned to each PERM cycle to:
  - ▶ serve as the state’s main point of contact for the cycle,
  - ▶ ensure that PERM timeline stays on track,
  - ▶ manage issues that may occur throughout a cycle.
- ▶ **CAP Liaison** – Each state is assigned a CMS Corrective Action Plan (CAP) Liaison. Once the measurement is complete, the CAP Liaison serves as the state’s main point of contact for the Corrective Action Plan process. The CAP Liaison provides technical guidance for identification of corrective actions to eliminate identified errors, frequently monitors the status of corrective actions, and is responsible for the collection of and response to the CAPs.

## CMS Contractors

CMS contracts with two vendors, an SC and an RC, to conduct the data collection, processing, sampling, and review of the FFS and managed care components of the PERM program and to calculate error rates. The SC is The Lewin Group, and the RC is A+ Government Solutions, LLC.

### *Statistical Contractor Responsibilities*

1. **Collect and sample FFS claims and managed care capitation payment data —** Each quarter of the fiscal year, the SC collects the universe of claims data from the state for its Medicaid and CHIP programs, including FFS and managed care data. The SC draws a random sample of claims or payments from each of the quarterly universes and sends the sample to the RC and the state. Routine PERM states populate sampled FFS claims with detailed service, provider, beneficiary, and payment information, which the SC validates, standardizes, and sends to the RC to facilitate medical review.
2. **Calculate state and national error rates —** The SC calculates:
  - state-specific FFS and managed care error rates;
  - state-specific program error rates based on the FFS and managed care error rates;
  - national FFS and managed care error rates; and
  - national program error rates based on the national FFS, managed care rates, and historical eligibility error rates.

### *Review Contractor Responsibilities*

1. **Collect state policies —** The RC will contact each state at the beginning of each PERM review cycle and will research and obtain all available state Medicaid/CHIP policy documents, fee schedules and provider manuals from state websites. A master policy list and policy questionnaire is compiled by the RC and sent to the state to verify in writing that the list is complete.
2. **Request medical records —** The RC is responsible for requesting all medical record documentation associated with randomly selected Medicaid and CHIP FFS claims requiring medical review. States can track medical record requests through the PERM RC's website.
3. **Conduct data processing and medical reviews —** RC conducts data processing reviews to determine if the claim was processed correctly or if an error resulted in an overpayment or underpayment. The RC also conducts medical review of medical record documentation, federal regulations, state-specific policies, and determines if each FFS sampled claim was billed, coded, and paid correctly and provided in the appropriate setting.
4. **Hosts and maintains the State Medicaid Error Rate Findings (SMERF) system —** The system is a web-based application used for tracking and reporting the sampling unit review findings for the PERM program.

## **State Required Teleconference Calls**

During the PERM cycle, states will be expected to participate in various teleconference calls, which include, but are not limited to, the following.

### **Cycle Kick Off**

Prior to each PERM cycle, CMS holds a cycle kick-off call with all 17 states in the cycle to give an overview of PERM, define CMS, state and contractor responsibilities, review any changes from the last PERM cycle, and discuss next steps.

### **Monthly Cycle Calls**

State PERM staff attends monthly cycle calls hosted by CMS. These calls serve as an opportunity for CMS to be in contact with the states throughout the PERM cycle and to maintain open communication. Cycle call participants consist of federal PERM contractors, the CMS PERM team, and all 17 states in the cycle. During the cycle calls, CMS and federal PERM contractors will provide updates on the PERM cycle review progress, give reminders about important due dates, let states know what they should focus on at that point in the cycle, discuss issues that have arisen during the measurement, and answer any questions states may have.

CMS will send out a request for agenda items in advance of each call. The state should then send any questions or items they would like discussed on the cycle call so that CMS has time to research each question/topic beforehand to ensure a complete and accurate response during the call.

Cycle calls are typically held at the same time in each month for a given PERM cycle (i.e. the second Thursday of each month at 2:30PM).

### **PERM General Education Webinar**

CMS will host several PERM General Education/Introduction to PERM webinars to provide a high-level introduction to PERM. These webinars are designed for individuals who will be involved with any aspect of PERM and who are not already familiar with the program. CMS will offer the same content on several different days and at different times to maximize participation. The state should encourage any staff that is new to the PERM project to attend one of the sessions. Experienced PERM staff is welcome and encouraged to participate as well. These webinars are held in September and October during the pre-cycle.

### **Claims Orientation (Intake Meeting)**

At the beginning of each cycle, the SC schedules a Claims Orientation or Intake Meeting with each state to prepare for data submission. During this meeting, the SC discusses data submission requirements and state shares information about the structure of its Medicaid and CHIP programs.

### **RC Educational Webinars**

The RC will host Educational Webinars before starting any reviews or medical record requests. The purpose of these webinars is to provide an overview of the PERM RC processes and to discuss the RC's role and responsibilities. This webinar will include details for the Data Processing Reviews, Medical Record Requests and Medical Review tasks, and



the States' responsibilities for each task. Webinars are usually scheduled between March and April of the review phase of each cycle. After the webinar, the RC will distribute questionnaires and working protocol documents for review and completion. These documents will help to assure accurate review of your sampled claims. The RC will also request verification of the completed Policy Questionnaire and Master Policy List to assure that previously located public policies and regulations are sufficiently comprehensive to conduct medical reviews.

### **Data Processing Orientation**

Prior to conducting the data processing reviews, the RC completes an entrance interview with each state. The purpose of this entrance interview is to review the completed system questionnaire and to collect any system manuals and guidelines needed for the data processing review of the sampled claims.

### **State Medicaid Error Rate Findings (SMERF) Orientation**

Prior to reporting initial review findings to the state, the RC holds several SMERF orientation webinars in May and June of the review cycle. The purpose of the webinar is to provide an introduction to the RC website to be used for state's tracking of review progress for each claim sampled, requesting difference resolutions and appeals and for accessing reports on final findings.

### **Details Intake Meeting**

The SC conducts a brief Intake Meeting with each Routine PERM state after the first fee-for-service sample is selected to prepare for details data submission. During the meeting, the SC will provide an overview of the details requirements to the state, collect information from the state regarding the population and submission of the details data, and answer any questions the state might have on the details submission process. The RC also participates in the meetings and may ask follow-up questions regarding the state's submission of claims details. The RC can answer any state questions about why specific piece of information is needed and how that information is utilized during the medical record review process.

### **CAP Kick-Off End of Cycle**

After the cycle cutoff, CMS holds a call with all 17 states in the PERM cycle to kick-off the corrective action process. The kick-off call outlines the corrective action plan (CAP) process, presents CMS' corrective action expectations, defines CMS and state responsibilities, highlights any differences since the last cycle, and discusses next steps for states in the CAP process.

### **Individual State Cycle Summary Findings Teleconference**

Once the state-specific error rate information is released, CMS holds an individual call with each state to discuss error findings. The call provides the opportunity for the state to ask questions about their error rates, targets, cycle summary reports, and the corrective action process.

## State Forum Call

CMS schedules a State Forum call to discuss best practices on how to develop a CAP plan. This is a state-led call for all 17 states in the cycle to discuss best practices and lessons learned from the cycle measurement.

## Post CAP Webinars/Onsite Meeting

After CAP submission, CMS holds post-CAP webinars/meetings with each state individually. These meetings discuss the state's submitted CAP, upcoming PERM initiatives, a recap of the cycle and upcoming PERM improvements for the next cycle measurement.

# 1. Eligibility Component

## Coming soon for FY 2018!

Due to the significant changes to Medicaid and CHIP eligibility as a result of the Affordable Care Act, the FY 2014–2017 PERM cycles will not include an eligibility component review. Instead, for these fiscal years all states will participate in Medicaid and CHIP Eligibility Review Pilots.

No state-specific PERM eligibility error rates will be calculated during this time. However, an estimated eligibility component error rate will be included in national-level PERM error rates. CMS will freeze each state's eligibility error rate at the rate from the most recently completed PERM cycles which would be the FY 2011 through FY 2013 cycles to develop the estimated eligibility component rate.

CMS is revamping the PERM eligibility review component and will issue a new PERM regulation and state PERM eligibility SOPs for the FY 2018 PERM cycle.

Any questions about the Medicaid and CHIP Eligibility Review Pilots should be sent to [FY2014-2016EligibilityPilots@cms.hhs.gov](mailto:FY2014-2016EligibilityPilots@cms.hhs.gov). Guidance regarding the PERM FY 2014-FY 2017 pilots can be found on the PERM website.

# 2. Claims Component Processes

## Claims Data Submission

The state must submit valid, complete, and accurate quarterly claims universes to the SC. Samples that will be reviewed to determine a state's error rate are selected from these universes submitted by the state.

## Universe Data

Universe data files are essentially very long “lists” of nearly all the Medicaid and CHIP beneficiary-specific payment records adjudicated by the state during the federal fiscal year under review. Claims and payments must be matched with either federal Medicaid (Title XIX) or CHIP (Title XXI) funds to be subject to review in PERM. PERM also collects denied and zero-dollar paid claims. Denials are claims and payments that would have been matched with Title XIX or Title XXI funds had the state approved the claims for payment. Zero-dollar paid records are those where the state has no liability due to a third party or a patient liability. The complete universe files are used to select the random sample of claims and payments for PERM review. Each claim or payment should be included one time in the universe so that



each payment has a chance, but only one chance, of being sampled for review to ensure that a representative sample of claims and payments is selected.

## **PERM Plus vs. Routine PERM**

The state is offered two data submission methods for PERM. Because each submission approach requires different data elements, the state must notify CMS and the SC of its choice via email by September 15<sup>th</sup> during the pre-cycle phase so that CMS and the SC can collect the necessary information from each state during the pre-cycle phase and Intake Meeting.

### ***Routine PERM***

- ▶ State creates PERM sampling universes based on whether a claim was matched (or would have been matched if not denied) with Title XIX (Medicaid) or Title XXI (CHIP) funds and the method of payment (claims or capitation)
- ▶ State removes adjustments, payments not matched by federal funds, payments not made on behalf of individual beneficiaries, and other exclusions by regulation, from the universe submission
- ▶ State submits a few key data elements required for sampling
- ▶ State creates details files containing additional fields required for medical record review for the sampled claims and provides the data to the SC

### ***PERM Plus***

- ▶ State submits data in a relatively “raw” format in a structure that is similar to how data are typically organized in claim processing systems: claims file(s), provider file(s), and beneficiary file(s)
- ▶ State will include information such as adjustments, state-only payments, aggregate payments, and informational-only lines which the SC will remove when building the universes
- ▶ State will indicate whether claims and payments are matched by Title XIX (Medicaid) or Title XXI (CHIP) funds
- ▶ SC builds the details file for the sampled claims

## **Claims Intake Overview**

The PERM FFS and managed care claims intake process begins when states are sent a Universe Data Submission survey on or around August 1. The survey is to be completed and returned to the SC within two weeks. The survey asks for information about changes to the state’s Medicaid and CHIP programs since the previous cycle and asks the state to provide a list of contacts that will be responsible for aspects of PERM.

After the Universe Data Submission Survey is returned to the SC, an Intake Meeting is scheduled with each state. The SC will conduct these meetings with each state individually at the beginning of the cycle after disseminating the data submission and details instructions, state-specific sample sizes and sampling plan. The Intake Meetings will discuss the requirements of the data submission and the structure of the state Medicaid and CHIP programs. CMS, the SC, and the RC attend these meetings. A few meetings are held onsite at the state’s premises and the rest are conducted via webinars and conference calls.

There are two main elements covered in the Intake Meetings – the PERM overview presentation and the Intake Protocol discussion. The overview presentation gives the state detailed information regarding the PERM data submission process including:

- ▶ PERM definition of FFS and managed care universes
- ▶ Overview of PERM sampling
- ▶ PERM universe exclusions and inclusions
- ▶ Suggested quality review checks for the state
- ▶ Quality checks performed by the SC on the PERM data submitted by the states

Depending on state's needs, there can also be presentations on data processing and medical record reviews.

The majority of the meeting is spent discussing the questions in the Intake Protocol. Before the meeting takes place, the state is given a copy of the protocol questions so that it can ensure that the personnel best able to respond to the questions are present at the meeting. This generally includes persons from claims processing, data, finance, managed care, waiver programs, third party administrators, policy, and any other agencies or entities that submit data or information for the state's Medicaid and CHIP programs. Participants should attend the meeting to participate in a dynamic discussion. The state is encouraged to ask questions relevant to the Intake process and PERM in general. Although prior preparation by the state personnel is highly encouraged, the SC does not accept written responses to the Intake Protocol questions. The meeting is intended to facilitate a discussion and follow-up questions are often posed. Question topics include:

- ▶ Structure of the Medicaid and CHIP programs
- ▶ Data sources relevant for the PERM universe or PERM Plus submissions
- ▶ Nuances of state data and how they conform to PERM formatting specifications
- ▶ Identification and exclusion of payments excluded by PERM guidelines and regulations
- ▶ FFS claim payment methodology including the level at which they are priced and paid (i.e., header, line, or fixed)
- ▶ Structure of managed care program(s), including types of full and/or partial capitation payments
- ▶ Waiver programs
- ▶ Aggregate payments
- ▶ CMS-64 and CMS-21 form preparation

This information is then compiled by the SC into the Intake Notes, which summarize the state's response to each of the Protocol questions. The Intake Notes are sent to the state for review, comment, and—if necessary—correction. The state is asked to approve or revise the Notes within two weeks. The Intake Notes assist the SC in the quality review of the data and often reduce the number of questions submitted to each state about its submitted PERM data.

### *Summary of State Responsibilities during Claims Intake Process*

- ▶ Submit completed Universe Data Survey by August 15<sup>th</sup>

- ▶ Ensure state personnel best able to respond to Intake Protocol questions attend the Intake Meeting (do not substitute attendance with written responses)
- ▶ Review and comment on Intake Notes within 14 days of receiving them from the SC

## Claims Universe Data Submission

For the federal fiscal year under review, states should submit universe data to the SC by the 15th day after the end of each quarter. Thus, Quarter 1 universe data are due on January 15, Quarter 2 universe data on April 15, Quarter 3 universe data on July 15, and Quarter 4 universe data on October 15. States must let the SC know as soon as possible if it foresees a delay in submission.

The SC's systems are capable of reading electronic data stored on a variety of media (e.g., CDs, DVDs, portable hard drives). It is preferred that the state send its data via Secure File Transfer Protocol (SFTP). However, if this is not possible, the state may submit data in an encrypted CD or DVD. Do not send PERM data via email. Details of how to transmit data via the SFTP will be sent to each state prior to the date of the first universe submission. For enhanced security, the PERM SFTP now uses a two-factor authentication before allowing users to access the site. State data submission personnel should carefully read the SFTP instructions and test their SFTP access prior to data submission deadlines.

The SC is capable of receiving data in a number of formats. Please refer to the Universe Data Submission Instructions for more detailed information on these formats. The state should also ensure that the universe data align with the specifications provided to the SC during the Intake discussions. For example, if a state informs the SC that the pharmacy claims would be submitted at the line level, the state should ensure that this is accurately reflected in the data or inform the SC that the information provided during the intake discussion was not an accurate representation of the data. The state should also ensure that all payment and claims data subject to PERM review from off-MMIS systems, waiver programs, and vendors (e.g., PBM) are submitted to the SC each quarter.

## Universe Quality Control Process

The SC performs a series of Quality Control (QC) checks to ensure that the PERM data submitted by the states meet PERM specifications as defined in regulation and the PERM Data Submission Instructions for both Routine and PERM Plus states. The PERM universe data must meet all PERM specifications to support the SC's review of the PERM data to ensure that the sample is selected from a compliant PERM universe. Major activities performed as part of the QC checks include standardization and validation prior to sampling and review, as defined below.

### *Data Standardization*

- ▶ The layouts of the submitted files match those stated in the documentation to ensure that the data can be read correctly
- ▶ If the submission does not conform to the standard layout recommended by the Routine PERM or PERM Plus Data Submission Instructions, standard field names and standard values are created based on the state-submitted data, so that the data can be compared between states, quarters, and fiscal years. However, to perform this step, the SC may have questions for the state, which must be answered in a timely manner.

### **Data Validation**

- ▶ The control totals in terms of the number of lines and the total paid amount provided by the state in the Transmission Cover Sheet during data submission matches the control totals calculated by the SC
- ▶ The claims data contain core fields and each field contains valid values that are listed in the data dictionary
- ▶ For the Routine PERM state, the data do not contain adjustments, information-only lines, state-only payments, and other payments/records that are not subject to PERM review. For the PERM Plus state, the data may contain these exclusions; however, the SC will request the state's confirmation prior to removing them from the universe.
- ▶ There is a reasonable and expected distribution of payment units and amounts by claim type, provider type, paid date, and across quarters
- ▶ Each record contains valid values for ICN/TCN, paid amount, paid date, claim type, payment level, and provider type
- ▶ There are no duplicate records, negative paid amounts, denials associated with non-zero payment amounts, paid dates outside the quarter, or missing lines for claims paid at the line level
- ▶ The submitted data reflect information provided by the state during the Intake Meeting, in state documentation, and other communication

The SC also performs the following QC checks specific to PERM Plus states:

- ▶ The provider and beneficiary data files contain core fields necessary for data processing and medical review
- ▶ Information for providers and beneficiaries with claim records in the claims files are available in the provider and beneficiary files

The PERM QC process involves multiple points of review by the SC to warrant that all PERM specifications are adhered to; the sample is selected from a complete, correct and compliant universe; each PERM record has one and only one chance of being sampled; and the sample and details data contain all the necessary information for efficient data processing and medical review.

During the course of the data review, the SC may seek clarification about the data from the state. These questions can range from simple questions such as needing file formats or data dictionaries to more complex ones regarding missing claims and payment data, or serious data irregularities. A timeframe for an expected response from the state will be included in communications. The time required for a response from the state varies from a few days to more than a week depending on the number and complexity of the clarifications requested. It is critical for the state to respond to SC questions within the required timeframes as delays in the universe QC process could lead to delays later in the PERM process such as sampling, medical record requests, data processing, and medical reviews.

### **Comparison of PERM Data Submissions to the CMS-64/21 Reports**

As a part of the PERM process, the SC conducts a comparison of each state's PERM universe data to the state's CMS-64 and as applicable, CMS-21 reports. This is done to ensure the PERM universe data contain all claims and payments for services provided to individual beneficiaries in accordance with PERM regulation and guidance.

The SC reviews the total dollar amounts reported on the quarterly CMS-64 and CMS-64 waiver reports for Medicaid and the CMS-64.21, CMS-64.21 waiver, and CMS-21 for CHIP, depending on the reports submitted by the state. The total dollars reported to CMS are then compared to the total dollars included in the PERM sampling universes for each quarter and annually. CMS defines a reasonable level of difference for this comparison as no more than a five percent difference in total dollars for the entire fiscal year and no more than a fifteen percent difference per quarter between the PERM data and CMS reports.

If the comparison between the PERM universe and the CMS reports results in a percentage difference greater than the established thresholds, the SC will work with the state to identify reasons for the discrepancy. The most common sources for differences are:

- ▶ Significant claims adjustments
- ▶ Prior period adjustments
- ▶ Non-beneficiary specific payments included in service lines of the CMS reports

In order to resolve these differences, the SC will provide the state with a summary of the comparison. This comparison is intended to help the state to begin identifying potential sources of the differences. The state will be asked to participate in the process by attempting to raise potential sources of the difference and involving the relevant state staff (e.g., PERM staff, financial staff responsible for the CMS report submissions, and relevant policy staff), and attending all scheduled calls. The SC may also request holding one or more conference calls with the state in order to discuss and resolve potential sources of the difference. Prior to these conversations, the SC will provide the state with a summary of the comparison findings.

Once the state has identified possible sources of discrepancies, the SC will ask the state to provide the financial information associated with the discrepancies (e.g., dollar amounts). The SC will then use this information to adjust the comparison in an effort to achieve a percentage difference between the PERM universe and the CMS reports that is within the threshold identified above.

## Sample Selection

The SC draws a random sample of claims from the quarterly Medicaid FFS, CHIP FFS, Medicaid managed care, and CHIP managed care universes from the data submitted by the states. The sampling methodology is shared with the state in the pre-cycle phase. Based on the methodology and the data received from the state, the SC puts together a proposed strategy to assign claims to the FFS sampling strata. The state is allowed two weeks to approve the proposed strategy. The annual sample sizes for Medicaid and CHIP FFS and Medicaid and CHIP managed care are state-specific based on the prior cycle's error rates and margins of error. The state will receive a copy of the sample once selected. A CMS regulation prohibits the PERM contractors from releasing the sample until 60 days have passed since the end of the quarter. Therefore, if a sample is selected within the 60-day timeframe, the SC will share the sample with the RC, but not with the state until the 60-day period is over.

The SC will draw the claims samples as soon as all the universe data have been received and quality control review is complete. The timeframe will vary for each state and universe depending on the time required to receive the data and the number and complexity of quality

control issues that are identified. Prompt responses by the state to questions during the PERM cycle will reduce the time needed to draw samples.

## Details Data

Submitting details information for sampled fee-for-service claims to the SC is a critical step in the PERM process for Routine PERM states. For PERM Plus states, the SC builds the details using the quarterly data submission. The RC uses the details information to request medical records and conduct medical reviews on sampled fee-for-service claims. Therefore, it is vital that the states submit accurate and complete details data or, for PERM Plus states, provide accurate and complete data during universe data submission that will allow the SC to create a state's details file.

### *Fee- For Service Claim Details Intake Process- Routine PERM States*

The SC conducts a brief "details" intake meeting (approximately one hour) with the Routine PERM states after the first fee-for-service sample is selected and returned to the state. These meetings are conducted via webinars and conference calls. The purpose of the meeting is to:

- ▶ Provide an overview of the details requirements to the states
- ▶ Collect information from the state regarding the population and submission of the details data, including any challenges the state might encounter in providing the requested data
- ▶ Answer any questions the state might have on the details process

The SC uses a details Intake presentation and a protocol to facilitate discussion during the Intake Meeting. Before the meeting takes place, the state is given a copy of the protocol questions and asked to ensure that the personnel best able to respond to the questions are present at the meeting. State staff involved with the collection and submission of details data should be present in the meetings. These include the state PERM lead as well as state policy and technical staff members who will extract and compile the details data from state payment systems (e.g., MMIS), compare and validate the data against the CMS Fee-for-Service Claims Details instructions for PERM-routine states, and submit the data to the SC via a password-protected secure FTP.

Discussion topics in the meeting presentation include the following:

- ▶ An overview of details submission process and requirements
- ▶ Description of crucial data fields and key pieces of information required in the details submission (e.g., beneficiary and provider information, medical service information such as diagnosis codes, dates and units of service)
- ▶ Review of suggested quality control checks that could be conducted by the state to verify that the details submission to the SC contains accurate information

Main topics in the details intake protocol include:

- ▶ Details File Structure and Layout
  - How the state will address multiple data sources in their details submission (i.e., will the state submit one file or separate files)



- Whether the state will submit the details in a combined header and line file, or in separate header and line files
- Whether the state plans to use the suggested field names and layouts in the details instructions or provide de-codes for the names and layouts of the fields that are used in the “State Details Crosswalk Template” provided with the sample
- Whether the state plans to provide any user fields in the details submission
- ▶ Details Data Validation
  - What, if any, required data elements are not available and/or may not be populated for all or some claims in the details data
  - Whether the state allows for fractional units of service for certain claims in the details
  - Whether the state anticipates any issues in submitting certain fields as they were originally adjudicated and submitted in the universe ( i.e., ICN, claim type, paid date, source location, payment status)

Responses from the meeting are then compiled into the Details Intake Notes and sent to the state for review, comment, and – if necessary – correction. The state is asked to send any questions or revisions to the SC within one week. After all questions have been answered, the Intake Notes are finalized, and a copy is sent to the state as well as the RC, which also participates in each state details Intake Meeting.

### *Summary of State Responsibilities during Details Intake Process*

- ▶ Ensure state personnel best able to respond to Intake Protocol questions attend the intake meeting (including the state lead as well as state policy and technical staff members who will extract and compile the details data from state payment systems (e.g., MMIS), compare and validate the data against the CMS Fee-for-Service Claims Details instructions for PERM-routine states, and submit the data to the SC via secure FTP)
- ▶ Review and comment on Details Intake Notes within 7 days of receiving them from the SC

### *Fee- For Service Claim Details Intake Process- PERM+ States*

For PERM Plus states, the SC creates the details based on the quarterly data submission. However, often questions due to state data anomalies and nuances arise during this process. To ensure that the SC and the RC can obtain clarifications of these issues through a discussion with the state, a brief details Intake Meeting might be conducted with the PERM Plus states after the first fee-for-service sample is selected and the details process is under way.

The focus of this meeting would be to share with the state the PERM Plus details process along with a question and answer session where the state would clarify the questions and issues faced by the SC while building the details data for the RC. These questions are sent to the state prior to the meeting to aid in preparation for the meeting. However, written responses ahead of time are discouraged to allow for a dynamic discussion. In attendance are state data, policy and technical staff; the RC; and the SC. These meetings are conducted via webinars and conference calls.

### *Details Quality Control Review Process*

For the Routine PERM state, submitting details information for sampled FFS claims to the SC is a critical step in the PERM process. For the PERM Plus state, ensuring that all information requested in the Data Submission Instructions is critical to the success of the details process. The RC uses the details information to request medical records and conduct medical review on sampled FFS claims. Therefore, in order for the RC to contact the applicable provider and review the associated medical record appropriately and efficiently, it is vital that states submit accurate and complete details data.

The SC performs a series of quality checks to ensure that the state-submitted FFS details data have been submitted accurately according to PERM specifications and that all required fields in the details are populated correctly and have non-missing, valid values. QC checks are conducted in stages broadly categorized as 1) data submission and 2) data validity.

### *Data Submission*

For Routine PERM states, the SC performs the following data submission QC checks upon receipt of the FFS details data:

- ▶ The control totals in terms of the number of lines and the total paid amount provided by the state in the documentation during data submission match the control totals calculated by the SC
- ▶ Information for mapping a state's field names to the standard details field names, data dictionaries and decodes for each field (as applicable) as well as any necessary file layouts are provided with each state data submission
- ▶ The details records match those that were in the universe from which the sample was drawn
- ▶ The paid date and the paid amount for all records sent by the state matches the original values submitted in the universe

For both Routine PERM and PERM Plus details, the SC conducts the following additional checks:

- ▶ The details data contain all fields necessary for medical record request and review
- ▶ The details data fields contain valid values or values that are listed in the data dictionary, as applicable
- ▶ The claims details include complete header and line information for each sampled claim

### *Data Validation*

The SC performs a series of checks on both Routine PERM and PERM Plus FFS details data to ensure the core variables in the details data do not contain missing values, contain valid values, are not truncated, and match the values in the sampled records. This is particularly important for the following key fields:

- ▶ **Recipient ID, Name, Date of Birth, and Gender:** Complete and accurate data for the recipient fields are critical for requesting medical records from providers.
- ▶ **Billing Provider and Performing Provider Information:** Information about name, type (where applicable), specialty (where applicable), address, phone number, and NPI



(where applicable) for both billing and performing provider are necessary for contacting the correct providers.

- ▶ **Medicaid Record Request Contact Information:** Name, address, and phone number of the medical record request contact should be included if the entity to contact to request medical records is different from the billing or performing providers.
- ▶ **Referring Provider Information:** Name and NPI information for referring provider, where applicable, must be included.
- ▶ **Dates of Service:** For line/detail paid claims, claim and line dates of service (from/to) are necessary. For header paid claims, at a minimum, header dates of service must be included.
- ▶ **Units Paid:** Verifying the appropriate units of service paid is one of the essential components of the medical review. Data for this field are particularly important for drug claims. All paid drug records in the details data must have valid units paid that are greater than zero. If the number of units paid for drug records are not available, the state is advised to provide the quantity dispensed or other similar and relevant data. In addition, for data in the “units paid” field that are not whole numbers and have fractional values (e.g., 3.5), it is important to ensure that the fractional values are valid and reflect the accurate number of units paid for the corresponding claim.
- ▶ **Total Computable Amount Paid:** This field should be populated for both header and line paid claims and should be net of any third party or patient liability, such as copayments and coinsurance.
- ▶ **Claim Type:** This field is the state claim type indicator, typically identifying whether the claim is an institutional, medical, pharmacy, or crossover claim. The values for this field in the details file should match to the values in the claim type field in the sampler file. However, a state data dictionary is required at the time of details submission if there are differences in claim type values between the sampler and details files.
- ▶ **Pharmacy Detail Information:** 11 digit NDC, prescription number, and drug order date are mandatory for medical review of drug claims.
- ▶ **Diagnosis Code:** Primary diagnosis code is mandatory for all claims except for drug and dental claims. State must include all secondary diagnosis codes as available.
- ▶ **Procedure, Revenue and DRG Codes:** ICD-9/10 procedure, DRG, revenue, and CPT/HCPSC codes for line level claims must be included in the details data as applicable.

In addition to performing these broad categories of quality checks, the SC performs a range of analyses on the PERM details submission to ensure that the data align with the notes from the Claims Intake and Details Intake Meetings and documentation sent by the state.

During the course of the data review and through the RC’s review, it is possible that the SC will seek clarification about the data from the state. Many times the RC will need to validate information in the sampled claim line or will need additional information to complete the reviews. When this occurs, the RC will communicate with the SC requesting the specific information needed. The SC will review the universe and details data for the required information. Next, the SC will send an email to the state PERM contact asking for the required information, and then a final response resolving the issue will be sent by the SC to the RC.

## Reviews

The RC reviews sampled Medicaid and CHIP claims and payments for correct payment according to state and federal regulations, policies, and procedural guidelines.

### State Policy Collection Process

The RC is responsible for acquiring Medicaid and/or CHIP policies for each state and maintaining a database that contains a complete set of policies for each selected state governing their respective Medicaid and/or CHIP programs, and which govern claims under review during the PERM review cycle. Policies used in the PERM review may include:

- ▶ Rules/regulations
- ▶ Manuals/handbooks
- ▶ Bulletins/updates/notices
- ▶ Clarifications/reminders
- ▶ Fee schedules/codes

The RC uses these policies during the review process to verify the claims are paid according to established requirements. The RC compiles and studies the policies prior to beginning data processing and medical reviews. They are used to determine the type of documentation required to be maintained by each provider type, service coverage and limitation guidelines, payment methodologies, and other associated rules and guidelines required by each state for proper payment of claims.

The RC will contact each state at the beginning of each PERM review cycle. The RC begins the policy collection process by researching the state website(s) for all available state policy documents that contain Medicaid and/or CHIP policy documents relevant to the data processing review and/or the medical review of claims, and downloads these from the state website. If a policy update alert system exists, the RC will apply to receive updates of all policy changes from the state. The RC then downloads all policies, converts them to text-searchable formats if necessary, and compiles a master list of all policies and a policy questionnaire for each state. After completion of the Master Policy List and Questionnaire, the RC sends them to the state and requests that they verify in writing that the list is complete (or supplemented when needed). The RC continues to collect state policies throughout the measurement year, and validates the list with the state as appropriate.

During the DP Orientation Meetings, the RC will request certain documentation that is not publically available on states' websites. This might include such documentation as system navigational guides, sample managed care contracts, fee schedules, etc. Additional documentation received will be categorized and stored on the RC's website, with all other policies collected, to assure that all reviewers have ready access to guidance for each state's reviews.

#### *State responsibility for policy collection*

- ▶ Provide documents requested for DP reviews that are not publically available on states' websites
- ▶ Provide final approved policy questionnaire to RC
- ▶ Provide final approval of Master Policy List

## Data Processing Reviews

Data processing (DP) reviews are conducted on each sampled FFS and managed care payment to validate that the claim was processed correctly based on information found in the state's claim processing system and other supporting documentation maintained by the state. A data processing error is a payment error resulting in an overpayment or underpayment that could be avoided through the state's MMIS or other payment systems. Claims not processed through a state's MMIS are subject to validation through a paper audit trail, state summary or other proof of payment.

The RC will conduct data processing reviews on both fee-for-service and managed care claims. The process may be performed on-site or remotely. For stand-alone CHIP programs, data processing reviews will be conducted during the same on-site visits for Medicaid claims or remotely, if the state prefers. When claims processing for CHIP are performed at separate locations independent of the state's MMIS, those locations will be visited at the same time as Medicaid scheduled visits to each state, when feasible, or may be scheduled separately.

The on-site review will consist of two to six weeks of reviews based on the state's sample size. An exit conference is held at the end of each weekly visit. In some cases, the state may prefer to have the team on-site for two consecutive weeks, which can be accommodated if planned in advance.

The RC will request data processing manuals, systems navigational tools, and pricing guides prior to and during the DP orientation visit if not available on the states' websites.

Note that in order to complete data processing reviews, the reviewer may need access to screens containing information on National Drug Codes (NDC)/revenue/procedure codes, payment rates and pricing schedules for all types of claims. The reviewer may need to access rates for older dates of service and if the state makes retroactive rate adjustments it will be necessary to access the rates that were in effect for the date of service on the claim under review. Information about how the state calculates each type of payment may be required. If the state processes payments for "sister agencies" that receive pass-through FFP at the federal match rate, (e.g., Medicaid in public schools, mental health), this information needs to be identified so pricing can be accurately determined. The reviewer may need access to other claims in the system in order to conduct a check for duplicates. Since the reviews include confirming the aid categories and date spans for the recipients, access to the eligibility system or a report or screen prints from the source system need to be made available at the time the reviews start. These arrangements need to be made in advance with the lead reviewer. The reviewers will have independent access to the OIG exclusions list, which will be used to verify whether any provider related to the claim (billing, rendering, or referring/ordering) has been excluded from Medicaid programs. If the provider filed a hard copy claim, access to the scanned image of the claim as well as the system information is required. Finally, the reviewer may need access to tables that explain codes used in the system (if this is not contained in the system help).

### *Data Processing Orientation*

A DP Orientation (or entrance conference) is scheduled with each state in advance of beginning the PERM data processing reviews. The orientation meeting can be held on site with the state or via a "Go-To-Meeting", at least six to eight weeks prior to the start of data processing reviews. On-site orientation meetings may be necessary when there has been a change in the state personnel designated to coordinate PERM since the last review, when

the state has implemented a new MMIS system, or when the state requests that the meeting be on-site.

The meetings can last between 1.5 to 6 hours depending on whether systems reviews are needed. A state that has multiple systems of record may need more than one day for the orientation. In addition, a state that has a separate fiscal agent or system for their CHIP program may need additional time for the orientation. At a minimum, the following personnel should attend these meetings: PERM Coordinator, claims manager(s), anyone who would be involved with determining whether to file a difference resolution (DR) or appeal for errors cited, person who pulled and sent data for the universe, person familiar with process for obtaining access to eligibility system, waiver program representative, CHIP program representative, or representative for any other special programs for your state.

Agenda items for the orientation:

- ▶ Introductions
- ▶ Review of the state system(s) questionnaires (completed in advance of the meeting by the state)
- ▶ Discussion of remote vs. on-site data processing reviews including requirements for each option (workspace, VPN or web access, etc.)
- ▶ Establish tentative dates to begin reviews, determine number of review staff, as well as what needs to be accomplished prior to starting reviews (establish log-on and passwords, systems forms, etc.)
- ▶ Review of any special programs (waivers, etc.)
- ▶ Review of state processes for documenting provider enrollment and risk based screening results
- ▶ Demonstration of any new systems (as needed)
- ▶ Determine and gather desk aids, manuals, and website links needed for training DP reviewers
- ▶ Review State DP Visit Checklist for a clear understanding of requirements to conduct DP reviews
- ▶ Meeting review and reiterate next steps

#### *State PERM Coordinator Responsibility for DP Orientation:*

- ▶ Respond to the DP Orientation invitation timely and help determine a date and venue for the meeting
- ▶ Make sure all appropriate people are invited to the meeting
- ▶ If the meeting is on-site make sure the conference room and projector are scheduled
- ▶ Make copies of all handouts in advance or send them to participants so they can make copies for the meeting
- ▶ Complete and return the systems questionnaire(s) at least one week prior to the meeting

#### *Prior to starting DP review (immediately following the DP Orientation meeting):*

- ▶ State will supply systems access forms, confidentiality forms, Data Use Agreements (DUA's) or other required documents for the assigned DP reviewers or RC to complete. This varies from state to state depending on their own systems security requirements.

- ▶ State will determine a location for the review team and make sure that state computers are set up and ready for the review team when they arrive to begin review. State computers are used to access the state's systems and to print screen prints as needed during the review.
- ▶ If the review is to be done remotely, a conference call is scheduled between the state IT personnel and the RC's IT personnel to facilitate reviewer access to the state's MMIS system(s).
- ▶ State PERM coordinator will alert subject matter experts to be available the week(s) the reviewers are on-site to answer questions, as needed. State will alert the security desk to expect the reviewers who will be on-site and arrange for visitor passes if required.
- ▶ State PERM coordinator and the lead DP reviewer will work together to make sure all arrangements are in place prior to the start of the reviews.
- ▶ The RC's DP lead reviewer will create desk aids (from materials gathered during orientation and from state websites) to populate in SMERF prior to the start of the reviews, for access by all DP reviewers assigned to the state review.
- ▶ Approximately six weeks prior to a scheduled on-site review, travel arrangements will be completed for all reviewers traveling to an on-site review. Reviewers generally travel on Sunday, work Monday through Friday. Work hours during the review week are based on a predetermined schedule agreed to by the lead reviewer and the state PERM personnel.

#### *State Responsibility prior to starting DP Reviews:*

- ▶ Make sure all information requested at the DP orientation is supplied to the lead reviewer at least two weeks in advance of starting reviews.
- ▶ Confirm an appropriate room is reserved for the reviews with space for two computers (A+ supplies computer for accessing SMERF; state provides computer for accessing MMIS) per reviewer and printing capability from the state supplied computer.
- ▶ Make sure all computers are in place prior to the day the reviews start.
- ▶ Make sure all systems forms have been completed (if required) and log-on and passwords created in advance of the on-site visit so the reviewers can start their reviews as soon as they arrive on the first day. This applies to all systems the reviewers will need to access, including MMIS, eligibility (if direct access is selected), and imaging or other systems such as dental or pharmacy if claims are not in MMIS.
- ▶ Notify building security that the reviewers will need access for the week and arrange for visitor or audit passes based on state's requirements. Also, advise the lead reviewer about parking requirements for the building.
- ▶ Submit the signed State DP Visit Checklist to the A+ lead reviewer to confirm State readiness to begin DP reviews.
- ▶ **For remote only:** Make sure state and A+ IT staff have worked together to get systems access established in time to start reviews as planned, and establish a help desk contact for access and password issues.

#### *On-site Data Processing reviews:*

For on-site reviews, the reviewers will usually arrive at 8:00 AM (or another agreed upon start time). Reviewers will normally work until 4:30 with a half-hour break for lunch; however, the

lead reviewer for each state will work with the PERM coordinator to establish a work schedule that is convenient for all involved in the PERM review process. The review team is flexible with work hours but need to be able to conduct reviews a full 8 hours Monday through Friday. Throughout the week, the lead reviewer will filter questions about specific claims review issues to the designated PERM contact from the state. These pending lists are updated at least daily. New issues will be added and resolved issues will be dropped off the report so the coordinator should work with the most recent list to avoid duplication of work. Ideally, all questions on pending issues should be answered while the review team is on site. It is important that all persons providing answers to the questions be available during the review week and understand the importance of responding as quickly as possible to the questions. This will reduce the number of pending issues as generally one answer applies to many reviews.

Usually on Friday of each review week, an exit conference will be held with the RC's lead reviewer and interested personnel from the state. During the exit conference, a report is distributed that discusses the number of reviews completed during the week, number of pending issues at the end of the week and itemizes any errors discovered. In addition, a final pending list is distributed and reviewed. Plans are made for return visits as needed during this meeting.

#### *State responsibility during on-site reviews:*

- ▶ Make sure subject matter experts (SMEs) are available to answer questions during the review week
- ▶ Review pending list daily and follow-up with SMEs to get needed answers back to the review team while they are on-site
- ▶ Work with lead reviewer to schedule an exit conference at end of the week
- ▶ Coordinate with IT to resolve any access issues encountered by the review team
- ▶ After the review week, the state will be given two weeks to provide any supporting documentation and answer any questions outstanding from the on-site review; additional time can be allowed if a subject matter expert is unavailable (usually two weeks).
  
- ▶ Review and monitor the Pending Report (P1 report) on the RC's website. This report will be accessible on the State's portal and exportable to excel to allow states to sort data as needed and to track all pending requests to completion.
  
- ▶ Follow up on P1 notifications (system generated reminder emails) that will be sent to States weekly to report all pending requests that are past due. State PERM Coordinators will be responsible to monitor all pending requests to assure that requested information is faxed or mailed to A+ to complete all pending reviews timely.

#### *Remote Data Processing (DP) reviews:*

States that have opted to have the PERM DP reviews conducted remotely will coordinate with the A+ lead reviewer to have all access and security forms completed prior to the date determined to start reviews. Work progress is slower for remote reviews than for on-site reviews. The review will normally take about six months to complete depending on availability of sample data. Pending lists will be sent out to the PERM coordinator every couple of weeks depending on work progress, and the PERM coordinator will be given a deadline (usually two



weeks) to respond to any pending issues. Exit conferences will be scheduled 2-3 times during the reviews to update the state on the progress of reviews, issues that need to be resolved, and to discuss any pending errors not previously discussed.

*State responsibility during remote reviews:*

- ▶ Make sure subject matter experts respond timely to pending issues throughout the review
- ▶ Work with the lead A+ reviewer to determine dates and times for exit conferences
- ▶ Make sure systems access issues are resolved timely

*Advanced Notification of Potential Data Processing Errors*

During the DP review the lead reviewer will let the state liaison know about any errors identified during the review week (usually confirmed at the exit conference). If the review is being completed remotely, the lead reviewer will discuss potential errors during email correspondence with the state liaison. Note: even though the lead reviewer may advise that an error is being cited during the on-site review, it is important to remember that all errors (Medical or Data Processing) require two full reviews by two different reviewers. Therefore, although the state may have become aware of an error during an on-site visit, it may take up to another month for the second level review of the error to occur. This is because the error may need to be forwarded to a reviewer in another location or because the second level reviewer determines that the error decision needs further research before finalizing. Therefore, one or more Sample Unit Disposition (SUD) reports may be issued before the error is actually listed on a report. When an error is finalized at the second level, an advanced notification of the error finding will be sent to the state that night. Then the error will be posted on the next SUD Report. These reports are generated on the 15<sup>th</sup> and 30<sup>th</sup> of each month during the review phase of the Cycle.

## **Medical Records Requests**

The RC is responsible for requesting all medical record documentation associated with the randomly selected Medicaid and CHIP FFS claims that will undergo medical review. The requests will be submitted directly to the provider's medical record location as verified by the provider.

*Medical Record Request Orientation*

RC Educational Webinars are scheduled in advance of beginning the PERM medical records request process. One of the goals of the webinar is to provide the state with the current PERM processes for MRR and to acquire any new state procedures for processing PERM requests.

*State PERM Coordinator responsibility for RC Educational Webinars:*

- ▶ Respond to the webinar invitation timely
- ▶ Reserve a conference room and equipment for participants of the webinar
- ▶ Make sure all appropriate people are invited to the meeting
- ▶ Make copies of all handouts in advance or send them to participants so they can make copies for the meeting

### *State responsibility prior to starting Medical Record Requests*

- ▶ Provide completed MRR questionnaire to RC
- ▶ Review and validate MMIS system provider contact information for claims
- ▶ Identify Fiscal Agents and Sister Agencies processes for management of medical documentation
- ▶ Identify special documentation processes or contact information for corporate contacts or multi-hospital systems
- ▶ Provide current contact information for state representatives

### *Original Documentation Requests*

Prior to sending the original (initial) letter requesting documentation, the RC contacts the provider and gives a brief introduction about the PERM program. The intent of the initial provider call is to verify the claim and the provider contact information and to obtain information on how the provider would like to receive the request (by fax or by mail). After provider contact information is verified, the RC will send the provider the official letter requesting documentation. Providers have a 75-day window from the date of the letter to submit the medical record documentation. At a minimum, the RC will send four follow-up letters and make four phone calls to each provider throughout the 75-day window, as needed, to follow up on documentation not yet received. The RC will send a fifth letter, a 75-day certified Non Response letter to the provider and a copy to the state representative if documentation is not received by the due date.

### *Additional Documentation Requests for Insufficient Documentation*

If documentation submitted by the provider is insufficient, the RC will send additional documentation request letters and make calls to providers. Providers have 14 calendar days to send in additional documentation. The RC will make 7-day reminder calls and send letters if documentation is not received from providers. The RC will send out 15-day certified Non-Response letters to providers and copies to state representative if documentation is not received by the due date. The RC will send out Receipt of Insufficient Information letters to providers and copies to state representative if documentation is received by the due date but is still insufficient.

### *Resubmission Documentation Requests*

The RC will send out Resubmission Documentation Request letters to the providers when one or more of the following issues is identified:

- ▶ Illegible copies of the medical record documents
- ▶ Incorrect dates of service submitted
- ▶ Medical record documentation submitted for the wrong patient
- ▶ Incomplete record submitted per state guidelines for the claim category
- ▶ No medical record documentation submitted with PERM Cover Sheet
- ▶ No recipient name and date of birth on medical record documents

### *Processing Late Documentation*

The RC will accept documentation until the cycle cutoff date. This means that even if the claim has already been called an error due to no, incomplete or insufficient documentation and difference resolution/appeals timeframes have passed, providers may still submit any



new documentation for review until the end of the cycle. State assistance in collecting these late records is essential in reducing documentation error findings. State follow up with providers should continue even after the 75-day and 14-day due dates have passed.

### *State Assistance with Contact Information*

If the RC is unable to verify the correct provider information from a state's claim file or outside research, the RC contacts the state's Medicaid/CHIP PERM Coordinator for assistance.

### *State Assistance with Obtaining Medical Records from Providers*

The state is expected to work closely with the RC for obtaining medical records from a provider. The RC will provide claim information and provider responsiveness to requests via the State Medicaid Error Rate Finding (SMERF) system. The states will utilize the SMERF system to monitor provider responsiveness to RC requests for medical records and tracking medical records requests. The RC will provide email notifications to states about when requests were sent to providers. The RC Health Information Management (HIM) Manager will collaborate and coordinate medical records requests with states to assure the timely processing of the medical record requests. The states will use the information from SMERF, the email notifications, and collaborations with the RC HIM Manager to follow up with providers to assure compliance with providing medical records to RC by the 75-day due date or cycle cutoff date.

### *State Best Practices for Obtaining Medical Records from Providers*

- ▶ Sending letters to each sampled provider about the PERM program and medical records requests processes before MRRs begin
- ▶ Providing RC with updated contact information on providers via excel spreadsheet or by email, when needed
- ▶ Identifying a contact person for corporate medical organizations, school systems, and state fiscal agencies
- ▶ Developing Integrity Teams to assist with locating and contacting providers
- ▶ Reviewing and editing contact information in the State MMIS
- ▶ Monitoring the status of medical record requests via the SMERF system

### *State responsibility during MRR process*

- ▶ Monitoring and tracking MRRs via SMERF
- ▶ Collaborating and communicating with RC about MRRs
- ▶ Responding to RC request for assistance with provider contact information
- ▶ Contacting providers about responding to MRR requests
- ▶ Reviewing encrypted CDs with medical records for errors identified and reported by RC to decide if the state wants to dispute the error findings
- ▶ Reviewing correspondence emails from SMERF and the RC

## **Medical Review**

Prior to conducting medical reviews, the RC conducts webinars for an overview and discussion of the policy collection and medical review processes for PERM. After the RC Educational Webinars, the RC will distribute the state's draft policy questionnaire and draft Master Policy List that were populated with the policy research results from the state's

website. The RC requests verification of the completed policy questionnaire to assure that previously located public policies and regulations are sufficiently comprehensive to conduct medical reviews. This provides the state the opportunity to clarify policies, if needed, and to ask questions relating to what to expect during the medical review process. Attendees to this orientation call/webinar should include state PERM coordinator, subject matter experts on relevant topics, and those who will be responsible for assisting the RC in obtaining policies, participating with the PERM review process, contacting providers to obtain records, and filing requests for difference resolution and/or appeals.

Medical review is conducted on all sampled FFS claims, with the exception of Medicare Part A and Part B premiums, Medicare crossover claims, primary care case management payments, aggregate payments, denied claims, and zero-paid claims. Medical review may be required for denied claims if the claim was denied for medical necessity or other reason verifiable only through review of the medical record. The medical review is exclusive of the data processing review. States can access or track medical review findings on the SMERF website.

A medical review error is a payment error that is determined from a review of the medical documentation submitted, the relevant state policies and federal regulations, and a comparison with the information presented on the claim. Medical reviews are performed to validate whether the claim was paid correctly in accordance with documentation submitted. Each claim is assessed to determine the following:

- ▶ Adherence to state's guidelines and policies and federal regulations related to the service type
- ▶ Completeness of medical record documentation to substantiate the claim
- ▶ Medical necessity of the service provided
- ▶ Validation that the service was provided as ordered and billed
- ▶ Claim was correctly coded in accordance with Coding Guidelines

#### *State responsibility prior to starting Medical Reviews*

- ▶ Provide final approved policy questionnaire to RC
- ▶ Provide final approval of Master Policy List

## Tracking Errors and Responding to Findings

The SMERF system is a web based application used for tracking and reporting review findings and medical record requests for the PERM Program. The CMS Regional Offices (RO), the SC, the RC, and the states all interact with the SMERF system. Each entity that interacts with the SMERF system has a web interface module designed for its specific purpose. The system is comprehensive and capable of assisting the PERM staff with access to Medical Record Requests, Error Rates, Data Processing Errors, Medical Review Errors, Sampling Unit Disposition (SUD) reports, Dispute Error Findings, Year-To-Date (Y-T-D) Errors, and Recoveries reports.

## Tracking Errors

Any errors identified through data processing or medical review are officially reported to the state through SUD reports which are available on the 15<sup>th</sup> and 30<sup>th</sup> of each month and which start the state's timeframe to dispute an error.

However, the state receives advanced notification of each error so it can start looking into errors as soon as they are identified. As soon as an error is identified through medical or data processing review, the SMERF system sends an automated email message to the primary and secondary state contacts for advanced notification of the error. The error will also be listed under the advanced notice of data processing errors menu or medical review errors menu on the SMERF website. Errors will remain on the advanced notice menus until the SUD Report is issued.

SUD Reports are created twice a month on the 15th and the 30th of each month. They contain results of data processing reviews and medical reviews conducted since the last SUD Report was created. Y-T-D SUD Reports contain results of data processing and medical reviews conducted since the beginning of the measurement period. SUD Reports and Y-T-D SUD Reports are created for both data processing reviews and medical reviews.

On the SUD Reports, errors are indicated with red-lettered error codes and deficiencies are indicated by green lettered codes. All data processing errors begin with the letters DP and all medical review errors begin with the letters MR. Deficiencies are DTD (DP) or MTD (Medical). C-1 represents a review with a finding of correct payment. The date of the SUD report starts the filing timeline for a difference resolution request. There is a one-week cutoff prior to the issuance of the SUD report, so errors that were completed within 7 days of the issuance date will usually not be available until the next SUD report.

## Requesting Difference Resolution

Once an error is posted on a SUD report, the state's opportunity to file a DR request begins. DR must be requested within twenty business days of the date the SUD report was posted.

A DR should be filed in the following circumstances:

- ▶ The state disagrees whether an error/deficiency was made.
- ▶ The state disagrees with the amount of the underpayment or overpayment (remember that medical review partial errors will initially be cited for 100% of the payment amount). The state must file a difference resolution request and provide written evidence to reduce the error amount to the difference between what was paid and what should have been paid when the error amount should not have been a 100% of the paid amount.
- ▶ The state has subsequently acquired additional documentation from the provider to submit to the RC to attempt to overturn the MR2 Insufficient Documentation. Please note that the state is not required to file a DR for submitting additional documentation obtained after a MR2 error finding. The additional information can be submitted to the RC (under the late documentation policy) and the claim will automatically reopen for another medical review up until the end of the cycle.

The state will have 20 business days to file a DR and supply documentation to support their position and evidence of re-pricing needed for partial errors.

### *How to File a Difference Resolution (DR) request*

Once the state has decided to file a DR request, the state liaison needs to access the SMERF website and enter the DR request by using the DR drop down. Click on cases available for difference resolution to find and select the review the state wishes to dispute. Please refer to the SMERF state user guide for detailed instructions along with screen prints of the process within SMERF. Note: Please do not enter any PHI into comments in SMERF and instead, indicate in comments if the state has faxed supporting documentation to the RC. The SMERF state user guide is available on the SMERF homepage under the tools menu item and on the login page with a link to this document.

Once the DR has been filed in the SMERF system, it is important to send supporting documentation, if needed, to the RC on the same day. To send supporting documentation to the RC, print out the fax cover sheet from SMERF immediately after filing the DR so that the documentation can be easily associated with the error the state is disputing. Send the fax coversheet (as the first page) along with the supporting documentation to 1 (877) 619-7850. SMERF will generate an email to the state to confirm receipt of the DR Request. It is important to create a DR fax cover sheet for each PERM review and submit the records independently from other submissions. However, if the same documentation applies to multiple PERM IDs, each PERM ID can be listed on the cover sheet so that the documentation can be filed with each applicable PERM ID.

### *Responding to a Difference Resolution Request*

Once the DR is filed by the state, the medical or data processing manager(s) will receive a notification that the DR has been filed. The RC will have 15 days to respond to the DR. Once the RC has determined whether to reverse, modify or uphold the original review decision, SMERF will send a notification to the state that a DR decision has been reached. At that time, the state liaison may access SMERF to view the results of the DR. If the state is satisfied with the decision of the RC, no further action is needed.

## **Re-pricing Partial Medical Review Errors**

During medical review conducted for the PERM program, sampled claims' medical records are reviewed for medical necessity, coding validation and accuracy of payment. In some cases, an error finding may be made (e.g., procedure coding error, number of units error) that would initially be reported as 100% error, but should only result in a portion of the payment being in error (partial error). The state is required to re-price partial errors using the DR process. The claim must be "re-priced" by the state under DR so that written re-pricing evidence can be submitted to the RC and the correct error amount can be calculated.

Types of errors that may partially affect payment include:

- ▶ MR 3 - Procedure coding error
- ▶ MR 4 - Diagnosis coding error
- ▶ MR 5 - Unbundling
- ▶ MR 6 - Incorrect number of units billed
- ▶ MR 10 - Administrative/Other

In addition to the above error codes assigned, the partial errors that need to be re-priced through DR will be noted on SMERF under the list of cases available for DR. The last column on the list is titled "needs to be re-priced" and the column is marked with a "Y" for yes to

indicate to the state that this is a partial error finding and a DR needs to be filed to correct the amount in error.

For partial medical review errors, the state can review the error amounts assigned to determine if it needs to be re-priced at the DR stage of review. State research of the correct payment amount can begin when the state receives the advanced error notification to allow time to gather evidence for re-pricing and to prepare for the DR opportunity.

The state has the opportunity to re-price claims with partial errors during the DR process. The date of the SUD report starts the filing timeline for a DR request. For partial medical review errors, if the state disagrees with the error finding, then it should submit records to dispute the error. If the state agrees with the error finding, but not the 100% error amount, the state must file a DR request in order to allow re-pricing and for the RC to correct the error amount. Written evidence must be supplied to the RC to re-price partial errors such as fee schedules, screen prints, etc. that would substantiate how the correct pricing amount was determined. The state will have 20 business days to file a DR and supply documentation to support their position and evidence of re-pricing needed for partial errors.

When the state supplies the re-priced amount, then the amount in error is calculated by taking the amount paid minus the amount that should have been paid. If the result is a positive number (less should have been paid), then the amount in error is an overpayment. If the result is a negative number (more should have been paid), then the amount in error is an underpayment. If the state does not provide a re-priced amount, then the error will be 100 percent of the paid amount for that sampling unit. If the documentation is not provided during DR or if the state does not request a DR, the full amount of the claim will remain as the error amount.

## **Filing an Appeal to CMS**

If the state still disagrees with the decision made by the RC after going through the DR process, the state may file an appeal to CMS. The state will have 10 business days from the date of the RC's DR decision to file the appeal. The RC will supply all documentation previously submitted for the review and the DR process to CMS including the medical record. The state may still submit additional documentation (not previously submitted to the RC) for CMS review. The state will follow the same process as used to submit a DR request in SMERF for submitting appeal requests (using the request appeal tab) to file the appeal. The state should send any additional documentation to the RC using the 1 (877) 619-7850 fax number or other secure methods for transmitting PHI. The appeal fax cover sheet can be printed from SMERF and must be used as the first page of the documentation packet submitted. The state SMERF user guide on the SMERF homepage contains screen prints and more detailed instructions of the process in the RC system.

The state, the RC, and CMS will receive an email confirmation once the appeal has been filed. CMS will convene a panel to review appeals and will usually reach a decision within 45 days. Once a decision is reached, it will be populated in SMERF and an email will be sent directing the state to view the results of the appeal in SMERF.

The appeal is the final step in the dispute process. There is no further recourse after the appeal decision has been made by CMS.

## End of Cycle Activities

The PERM cycle normally ends the summer after the fiscal year under review (i.e., the FY 2014 cycle will end in the summer of 2015). States have many important responsibilities at the end of a PERM cycle.

### Cutoff Date

CMS sets a cycle cutoff date for each cycle to ensure that error rates are reported timely. For the RC to review documentation or respond to a difference resolution request, etc., the request must be submitted before the cycle cutoff date. Error rates will be calculated based on information received from states/providers by the cycle cut-off date. This is an external date for CMS to receive information, not for completing reviews. The RC will review documentation received by the cycle cut-off date, and any difference resolution/appeals requested by the cut-off date will be completed for error rate calculation.

Typically, the cycle cut-off date is the second July 15 of a measurement cycle. However, the cycle manager may push back the cycle cut-off date depending on the progress of the cycle and will notify the states through emails and cycle calls.

Since CMS accepts late documentation, it is essential that states continue to follow up with providers to try to obtain the necessary documentation before the cycle cut off. If a provider's 75 day or 14-day timeframe for documentation submission has passed but documentation is submitted by the cycle cut off, the RC will still review it. Likewise, if a claim was called an error due to lack of documentation and the difference resolution and appeals timeframes have passed but documentation to support the claim is submitted by the cutoff date, the RC will review it. CMS encourages states to utilize the "Estimated Impact on Error Rate" report available on the state portal in the SMERF website to help focus any last minute outreach efforts on those errors that are going to have the biggest impact on the state error rate. CMS will also make calls to providers in an attempt to obtain documentation for those missing or insufficient documentation errors (MR1 and MR2) that have the biggest impact on the national rate and will coordinate with your state during this process.

Documentation received or difference resolution/appeals requested after the cycle cut-off date will not be included in national error rate calculations. Therefore, in instances where a state's 20-day timeframe for requesting difference resolution may extend past the cycle cutoff date, CMS encourages the state to request the difference resolution by the cutoff date and not wait the full 20 days. These instances, however, may be eligible for continued processing.

### Continued Processing

Continued processing occurs when a claim did not have time to go through the full PERM process before the cycle cut-off date. Examples include: (1) Medical records for a claim were received after the cycle cut-off date but within 75 days of the initial request for medical records, or (2) An error was cited before the cycle cut-off date but the state's allowable timeframe to request difference resolution and CMS appeal extended beyond the cut-off date.

Claims will complete the PERM process through continued processing, and CMS will recalculate a state's error rate based on the continued processing results. Thus, it is important that the state continue to respond to errors even after the cycle cutoff has passed.



By PERM regulation, providers must submit medical documentation within 75 calendar days of the initial request from the RC or by the cycle cut-off date. Therefore, CMS will not accept any new documentation after the cycle cut-off date that is not part of continued processing. However, if a state has documentation to support that a claim previously called an error was correctly paid (e.g., successful provider appeal results, claim adjusted after PERM 60-day window), it can work with the CMS Regional Office financial contact to determine what adjustment to the expenditure reports is required for recovery purposes.

## Recoveries

The state is required to return the federal share of Medicaid and CHIP FFS and managed care overpayments identified through the PERM review on a claim-by-claim basis.

### *Requirements*

The state has one year from the date an overpayment is identified to return the federal share. For most PERM overpayments, the date of identification is the date on which the overpayment is reported on the state's Monthly PERM FEFR report. For overpayments caused by MR1 (no documentation) and MR2 (insufficient documentation) errors, the date of notification is the date of the last monthly FEFR report issued that includes the MR1 and MR2 errors. The RC will also create an End Of Cycle FEFR after all continued processing reviews are completed which will include a comprehensive list of all overpayment errors previously reported on monthly reports.

The state returns the federal share of identified FFS and managed care overpayments through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) on the CMS-64 and/or CMS-21 expenditure reports. PERM recoveries for Medicaid that are collected by the state during the one-year period or voluntarily returned by the state to CMS during the one-year period should be reported on Line 9F of the CMS-64. PERM recoveries that are not collected from the provider within the one year period should be reported on Line 10D of the CMS-64. PERM recoveries for CHIP should be reported on Line 4 of the CMS-21.

Each state should involve their financial staff for tracking PERM recoveries/overpayments. Throughout the recoveries process, the state should work with the CMS PERM Recoveries lead that will coordinate with the state's CMS regional office financial contact.

### *Reports*

#### *Monthly Final Errors for Recovery (FEFR) Report*

Monthly FEFR reports are generated throughout a PERM cycle and include overpayments on claims that have undergone both a data processing and medical review and all difference resolution/appeals timeframes have expired (in other words, errors show up on FEFR reports when they are final and have no chance to be overturned). Monthly FEFR reports are posted on the Review Contractor's State Medicaid Error Rate Findings (SMERF) website on the first business day of the month and are considered the state's official notification of an overpayment. Please note that since CMS accepts provider documentation until the cycle cutoff, no documentation or insufficient documentation errors (MR1 and MR2) are final until the end of the cycle. Therefore, MR1 and MR2 errors are not included on Monthly FEFR reports until the last FEFR report is created after the cycle cutoff date. State Medicaid and

CHIP Directors are sent the official notifications via emails. The PERM state lead/contacts and CMS Regional Office financial contacts are also copied on these emails.

### *End of Cycle Final Errors for Recovery (FEFR) Report*

The End of the Cycle FEFR report is posted to the SMERF website for a state after continued processing is completed and once all findings are final for the state for that cycle. The End of Cycle FEFR reports serves as the final list of overpayments for which a state must return the federal share for a PERM cycle. The report includes the total computable amount for the cycle. State' Medicaid and CHIP Directors are also sent the official notifications via emails.

### *Exceptions*

There are some exceptions to the requirement to return the federal share of an overpayment within one year of identification:

- I. ***A collection is received from the provider*** – If the state receives recovery of the overpayment from the provider, the one-year rule no longer applies. When the state receives the collection, the state must return the federal share on the next quarter ending CMS-64 and/or CMS-21 expenditure report.
- II. ***The claim was adjusted to the correct amount*** - PERM reviews claims paid or denied in each quarter of the federal fiscal year and includes adjustments made to the claims within 60 days of the original paid date. Thus, overpayments could be identified for claims that were later adjusted to the correct paid amount outside of the 60-day window. In such instances, the state is not required to return the federal share. The state should notify the PERM Recovery Lead and provide documentation (e.g. screen shots, etc.) of the adjustment.
- III. ***Provider successfully appeals to the state*** – If a provider successfully appeals the error to an Administrative Law Judge (ALJ) the state can submit proof of the ALJ decision to the PERM recoveries lead and will not need to return the federal share of the overpayment. Many states have an informal appeals process in place that is preferable and less time consuming than a formal ALJ appeal. If an error is overturned through an informal appeals process the state should submit documentation to the PERM recoveries lead and CMS will review the documentation to determine whether the federal share needs to be returned.
- IV. ***Provider submits documentation after the cycle has ended*** – After the cycle is over, when states send out recovery demand letters to providers, providers sometimes submit the outstanding medical record to the state (mostly for MR1 and MR2 non-response errors). Since this occurs after the cycle cutoff date, the claim will still be an error for PERM but CMS cannot in good faith request states to return the federal share if there is sufficient documentation to support the claim was paid correctly. The state should send the documentation to the PERM recovery lead through a password protected and encrypted CD. As a reminder, please do not send PII nor PHI information through the email. CMS' PERM appeals panel will review the documentation and evaluate whether or not the claim was correctly paid based on the new documentation.



### *Underpayments*

Underpayments are not included on PERM FEFR reports and are not a part of the PERM recoveries process. Typically, CMS is entitled to the Federal credit for overpayments whether the state has collected from the provider or not. However, CMS would not credit an underpayment until the underpayment was actually corrected and paid at which point it would be reported as a normal operating expense and not an adjustment on an overpayments schedule.

## Post-Cycle Documentation

States participate in PERM on a three-year cycle. This means that once data collection is complete for one PERM cycle, it will be over two years until data collection starts for the next PERM cycle (e.g., for FY11 the last data submission was due on October 15, 2011 and the first data submission for FY14 will be January 15, 2014). Post-cycle documentation is a critical part of the PERM cycle. Documenting key staff, data sources, programs, and technical issues at the end of the current cycle can save states many hours of work in future PERM cycles. The state should document the following items at the end of a PERM cycle:

- ▶ **Key staff:** A list of the names and positions of all state staff, fiscal agent staff, and staff from outside vendors who worked on PERM. Knowing who worked on PERM in the past, their role on PERM, and their level of involvement in the measurement can help states retain knowledge about PERM and reduce the impact of any staff changes for the upcoming PERM cycle.
- ▶ **Data sources used in PERM:** Many states process some of their claims matched by Medicaid (Title XIX) or CHIP (Title XXI) funds in claims processing subsystems outside of the main MMIS. These claims are submitted in the PERM universes along with claims data from a state's main MMIS. A list of these off-MMIS claims data sources ensures that they will be easily identified in the upcoming PERM cycle.
- ▶ **Programs and payments excluded from PERM:** Make a list of programs and payments in Medicaid and CHIP that were considered for PERM review in the current cycle but were excluded. State should also include a brief reason why the program or payment was not reviewed by PERM. PERM data review methods are always being improved, and it is possible that a previously excluded program or payment could be included in PERM with changes in PERM methodology.
- ▶ **Computer programs used for PERM:** The file specifications for PERM universes, PERM Plus data submissions, and PERM sample details will be relatively similar from cycle-to-cycle. Once programs have been developed to collect PERM data, the state will want to use the same programs, with modifications, in the upcoming PERM cycle (barring any system changes that might occur between cycles). Therefore, the state will need to identify and document all computer programs used to collect PERM data and create PERM universes, details, and other data submissions.
- ▶ **Technical issues:** It is possible that policy and data issues could be discovered during the course of the PERM cycle which could continue to be issues for the PERM data submission in subsequent cycles. These issues do not necessarily imply any problems with a state's MMIS or other claims processing systems, but are a result of how PERM rules and regulations interact with state claims data. For example, PERM rules require that Medicaid managed care stop loss payments are reported in the Medicaid fee-for-service universe. A state may actually store the stop loss payment records in its Medicaid managed care payment subsystem. The state would have a documented process to address the technical issue of how to move the stop loss payment into the

PERM fee-for-service universe. Documenting long-term cycle issues and how those issues were resolved for PERM will save time in the upcoming PERM cycle.

### 3. Error Rate Reporting

#### Overview

##### Overview of Error Rate Calculations

All payment error rate calculations for the Medicaid and CHIP programs are based on the ratio of estimated dollars of improper payments to the estimated dollars of total payments. The error rates for Medicaid and CHIP are calculated separately and are not combined. The PERM error rates are calculated by the PERM Statistical Contractor (SC) once the cycle findings have been finalized. This typically occurs in the late summer/early fall of the year following the fiscal year being measured.

##### Projected Dollars in Error for State Error Rates

In order to calculate the error rates, both estimated improper payments and estimated total payments are first calculated using sample improper payments and sample total payments. PERM follows a stratified sampling design for each state. For the fee-for-service universe, the strata are based on service types in state universes while for managed care universe, the strata are dollar-weighted (i.e., each stratum has an equal value of dollars). PERM randomly selects a predetermined number of units within each stratum and each sampled unit is assigned a sampling weight based on the probability of being sampled from that stratum. The sample improper payment and paid amount are multiplied by the sampling weight associated with each of the sampled units in order to calculate the “projected” improper payment/paid amount for that sampled unit.

##### Calculation of State Error Rates

For each state, three dollar-weighted error rates are calculated: fee-for-service, managed care, and overall. Error rates for fee-for-service and managed care are calculated separately by adding the total projected improper payment/paid amount for each component within each state and then calculating the percentage of improper payment to paid amount. Then, the component error rates are combined to form the overall state error rate.

##### Projected Dollars in Error for National Error Rates

Like the state error rates, there are three dollar-weighted error rates calculated nationally: FFS, managed care, and overall. Since 17 of the 51 states are sampled each year, in order to calculate the national error rate, the three most recent years’ data are pooled. For each state component, the sample improper payment amount for each state is multiplied by their respective sampling weights to calculate the state error rate. The national improper payment rate for a component (i.e., FFS, managed care, overall) is calculated as a weighted estimate of the 51 state rates where the weights for each state is the share of state payment for the component.

As noted above, no state-specific PERM eligibility error rates will be calculated during this time. However, an estimated eligibility component error rate will be included in national-level overall PERM error rate. CMS will freeze each state’s eligibility error rate at the rate from the

most recently completed PERM cycles which would be the FY 2011 through FY 2013 cycles to develop the national overall PERM error rate.

## Calculation of National Error Rates

National dollar-weighted error rates for fee-for-service and managed care are calculated separately by adding the national projected improper payment/paid amount in each component and then calculating the percentage of improper payment to paid amount. The national rolling error rate includes the latest projected improper payments and projected total dollars from 50 states and the District of Columbia so that each state is represented in the national level statistics. The frozen FY 2011 through FY 2013 national eligibility error rates will also be combined with the national fee-for-service and managed care component rates to form the overall national error rate.

### *Error Rate Notifications & Cycle Summary Reports*

States receive official notification of their results through the Error Rate Notifications and Cycle Summary reports. These reports are also posted on the RC's website and are typically released around November 15<sup>th</sup> the year after the fiscal year under review (i.e. FY 2014 error rate reports will be released November 2015). Each state receives two reports, one for Medicaid, and the other for CHIP.

The notification reports give the state's error rates for fee-for-service and managed care along with the year's sample size for each of these components. The overall error rate and sample size is also provided. Along with the current year's results, the projected sample size for the state in the next PERM cycle and target error rates for the next cycle are also given in the report. Both the projected sample sizes and target error rates are based on the current component and overall error rates of the state.

The cycle summary reports contain detailed data analysis of the state's Medicaid and CHIP error findings. The states can use these reports to further analyze the results of the PERM cycle for each component. The reports can also be used as the basis for each state's approach to their corrective action plans.

### *Error Rate Recalculations*

If the state has any claims that went through continued processing and errors were overturned/error amounts changed, CMS will issue a recalculated error rate once continued processing is complete. The state will receive an Error Rate Recalculation Notification document. A new projected sample size for the next PERM cycle is also calculated based on the new error rates. These reports will also be posted on the RC's website. However, the target error rates for the next cycle are still based on the original component error rates.

A state's error rate is factored into the official national three-year rolling error rate for three years. Error rate recalculations will not be included in the first year error rate because the recalculations occur after this number is reported. However, state-specific error rate recalculations will be included in the next two years a state's error rate is included in the rolling rate.

## 4. Corrective Action Process

Following each measurement cycle, each state included in the measurement is required to complete and submit a Corrective Action Plan (CAP) based on the errors found during the

PERM process. CMS provides guidance to state contacts on the CAP process upon publishing of the PERM error rates and throughout the CAP development until the specified due date of the CAP. The specified due date is 90 calendar days after the date on which the state's error rates are posted on the RC's Website.

The CAP process involves analyzing findings from PERM, identifying root causes of errors, and developing corrective actions designed to reduce major error causes, trends in errors, or other vulnerabilities for purposes of reducing improper payments. The new CAP should also include an evaluation of the previous submitted CAP. Through the CAP process, states are able to take administrative actions to reduce errors that cause improper Medicaid and CHIP payments.

## **CAP Process**

### **CAP Kick-off Call**

In September, after the conclusion of the measurement review and prior to publishing the states' error rates on the website by the RC and in the Agency Financial Report (AFR), the PERM CAP Team will have an initial "CAP kick-off call" with all states in the measurement to discuss the corrective action process. Prior to the call, several documents are forwarded to the state for review. These documents include a Power Point presentation explaining the CAP process, the October 2007 State Health Official (SHO) letter, CAP instructions, and a "kick-off call" agenda. The states are encouraged to invite whomever they feel needs to be included in this kick off conference call.

### **Individual State Calls**

The next contact with the state is in November after the official error rate has been released and the contractor has posted the states error rate on the RC's website. Individual state specific calls are made to the 17 states that were a part of the yearly measurement process to discuss the state specific CAP template and the Cycle Summary report, which includes an Executive Summary, and state-specific error analysis findings that are prepared by the contractors.

### **State Forum Call**

CMS provides each state in the CAP phase of the PERM program with the opportunity to have a "State Forum Call" in which CMS provides a conference call line for the states to use and discuss best practices as they relate to developing corrective actions. While CMS provides the conference call line, a state volunteer within the cycle facilitates the discussions amongst the states. After the first state forum call, states may decide whether a second call is needed for further discussion.

### **Corrective Action Panel**

The key to a successful CAP is the formulation of a corrective action panel. The panel in turn must encourage participation and commitment of top management to coordinate efforts across the Agency and ensure participation of major department leaders.

Senior management could include managers responsible for policy and program development, field operations, research and statistics, finance, data processing, human resources (for staff development), and the legal department. These managers would

comprise the corrective action panel. Leadership of the panel should rest with the State Medicaid or CHIP Director.

Responsibilities of the corrective action panel include:

- ▶ Providing insight on possible causes of errors
- ▶ Communicating the CAP progress to management and other stakeholders
- ▶ Developing strategies
- ▶ Making all major decisions on the planning, implementation and evaluation of corrective actions

### *Components of the Corrective Action Plan*

States will receive a pre-populated state specific CAP template for both Medicaid and CHIP. States are required to complete every section of the CAP template and address every error. The CAP template is based on information that went into the official state error rate, so this will include errors that were overturned during continued processing. States are not permitted to delete any portion of the CAP template. States are required to submit a separate CAP for Medicaid and CHIP. CAP instructions are included on the PERM website under the CAP tab along with the CAP checklist and CAP presentation.

CAPs are composed of five elements that are required by regulation. The five elements are: data analysis, program analysis, corrective action planning, implementation and monitoring, and evaluation.

### *Data Analysis*

Number of errors and dollars in error for each qualifier within the error category will be pre-populated in the CAP template by CMS. Space is provided for states to enter additional optional data analysis if they would like to add more information about the nature of the error. Data analysis enables the state to gain a more thorough understanding of the root cause of the errors, when the errors occurred, and who or what caused the error. For example, this error accounted for 10% of the total errors (5) identified during the medical records review. It resulted in a total overpayment of \$100. The error occurred because the personal care assistant documentation was not maintained in accordance with state policy to support the 10 units of procedure code T1019 (Personal care services, per 15 minutes) for the date of service sampled.

### *Program Analysis*

This component is the most critical part of the corrective action process where the state must review the findings of the data analysis to determine the specific cause of each error. The state must identify the root causes of the errors to determine the best solutions (e.g., why providers are not complying with medical record requests). The state may need to analyze the agency's operational policies and procedures and identify those policies and/or procedures that are more prone to contribute to errors, e.g., policies are unclear, lack of operational oversight at the local level.

Program analysis, along with data analysis, provides the framework for evaluating relevant information to determine the facts and causal factors in order to develop the most appropriate, timely corrective actions to resolve the finding and prevent recurrence. If errors

look to have been caused by inadequate training, then the state should take actions to strengthen its training programs. This could be accomplished by worker interviews, questionnaires, policy reviews, and conferences with local managers, etc.

The state must explain how its program analysis activities address 100% of the payment error-types. Although a state may not be inclined to plan corrective actions for one-time error situations, such as human error, or corrective actions which are not cost-effective, states must nevertheless at least address each error.

The state should describe how program analysis activities go beyond the surface cause (nature) of an error and look to the root cause and describes actions that the state is taking to meet or exceed its PERM error-rate target, as specified by CMS. The state should discuss why a particular program/operational procedure caused the specific error and identify the root causes of errors.

All errors should be addressed, including deficiencies.

### *Corrective Action Planning*

Based on the data and program analysis, the state must determine what corrective actions are to be implemented. The state is encouraged to use the most cost effective corrective actions that can be implemented, to best correct and address the root cause of each error. Actions can be short or long term. Benefits of implementing corrective actions include the reduction of improper payments and a management tool to promote efficiency in program operations.

The state should explain the overall approach towards CAP planning, identify its PERM error-rate target goal, as specified by CMS, and explain actions that the state is taking to meet this target goal. The state should describe the corrective action initiatives to be implemented and how these actions will reduce or eliminate improper payments, including:

- ▶ Specific error causes being targeted
- ▶ A timeline listing expected due-dates for resolving the problem(s) (causes of errors)
- ▶ Description of the plan to monitor implementation of the corrective action plan
- ▶ Specify the name and title of the person who has overall responsibility for the CAP

Beginning with the FY 2013 cycle, states are required to include corrective actions for eligibility technical errors.

### *Implementation and Monitoring*

The state should develop an implementation schedule (timeline) for performing corrective actions and describe the tasks necessary for CAP implementation and tie those tasks to the implementation schedule specifying milestones and implementation dates. The state should note whether the corrective action is statewide or just in certain geographical areas. The implementation schedule must identify major tasks, key personnel or components responsible for each activity, a timeline for each action including target implementation dates, milestones (e.g., start dates, final implementation dates), and the monitoring process.

Federal regulations also specify that states must monitor their CAPs. The purpose of monitoring is to determine whether the implemented CAP is in the process of yielding intended results and meeting identified goals for reducing errors. Monitoring activities are



ongoing, operational activities the state undertakes while CAP activities are being implemented. Monitoring activities enable a state to keep track of its organization's ongoing efforts to reduce its PERM errors. An integral part of a successful corrective action program monitoring is maintaining a systematic approach for tracking and reporting the status of the corrective actions to successful closure and implementation.

The state should describe its CAP evaluation activities and describe actions taken to monitor implementation of the CAP.

The state must address each error type; however, it remains the state's decision which corrective actions they take to decrease or eliminate errors. It may not be cost effective to implement corrective actions for each error. CMS understands these situations and does not encourage states to make inefficient fixes. It may be helpful for the state to perform a cost benefit analysis to calculate the total expected cost of corrective actions against the benefits of corrective actions. If the state determines the cost of implementing a corrective action outweighs the benefits then the final decision of implementing the corrective action is the state's decision. If there is an instance where the state chooses not to take definitive corrective action, the state should explain this in the CAP and the rationale for doing so (quick fix, no potential cost savings, resources, etc.).

### *Evaluation*

The state must evaluate the effectiveness of the corrective action by assessing improvements in operations and/or error reduction. The state may then decide to discontinue, modify, or terminate and replace the corrective action. The state must evaluate the current corrective actions to be implemented by assessing all of the following:

- ▶ Improvements in operations
- ▶ Efficiencies
- ▶ Number of errors
- ▶ Improper payments

### *Evaluation of Previous Cycle CAP*

As part of its new CAP, the state must evaluate and include updates on the previous corrective actions taken in their prior cycle including:

- ▶ Effectiveness of implemented corrective actions using reliable data; such as performing special studies, state audits, focus reviews, etc.
- ▶ When the action was implemented
- ▶ A status of the corrective action (is it complete, in progress, or ongoing?)
- ▶ Expected completion date and if the corrective action is on target
- ▶ Actions not implemented, and those actions, if any, that were substituted, ineffective, or abandoned and what actions were used as replacements
- ▶ Findings on short-term corrective actions
- ▶ The status of the long-term corrective actions
- ▶ State should determine if it meets PERM error-rate targets as identified by CMS

The state should utilize the Medicaid FFS and managed care comparisons information in their cycle summary report to evaluate the effectiveness of the corrective actions taken in the previous cycle.

### *Corrective Action Plan Submission Details*

CAPs are due to the assigned PERM state liaison 90 calendar days after the date on which the state's error rates are posted on the RC's website. However, CMS encourages states to submit drafts to their designated PERM state liaison prior to the due date to receive feedback prior to the final CAP submission date. While drafts are not required, they are strongly encouraged. Once the drafts are submitted, CMS will review them and provide additional feedback that states can incorporate into their final CAP submission. Final CAPs are submitted by the state to the appropriate PERM state liaison for review and distribution to the member of the collaboration workgroup. Each state will receive a letter of receipt acknowledging their CAP submission upon receipt of their completed, final CAP. After review of the CAPs by all parties, an individual call may be held for further discussion if there are additional questions or concerns.

The CAP instructions can be found on the PERM website under the CAP tab along with the CAP checklist and CAP presentation.

### *Post CAP Submission Activities*

**March 15 through end of April** — After all CAPs have been evaluated, the PERM state liaison, CMS RO PERM contact, and designated MIG staff, if needed, will participate in a conference call with each state to discuss the findings, request clarification, and determine if additional information should be requested from the state.

**Webinars and Onsite** — Each state is required to have a webinar or onsite visit. This is an opportunity for active dialogue between the state, CMS, Regional Offices, Medicaid Integrity Group, and CMS' contractors. CMS presents information to the state on PERM initiatives and proposed improvements to the next PERM measurement. The state is required to do an oral presentation of their CAP and presentations that provide a high-level overview of findings and mitigation strategies are encouraged.

**Follow-up**—The CMS CAP liaison will contact states on an annual basis to follow up on the state's CAP implementation status between cycles.

The state should expect to participate in the following CAP related activities:

- ▶ Cycle summary findings call
- ▶ Establishing a Corrective Actions Panel
- ▶ Participate in the Best Practices teleconference call with CMS
- ▶ State forum call
- ▶ Work with designated CMS CAP liaison on an ongoing basis
- ▶ Submitting CAPs within 90 days after the Annual Financial Report is published. CAP liaisons will provide feedback and recommendations on drafts submitted in advance of the submission deadline

## 5. PERM Initiatives and Available Resources

### PERM Provider Education

In efforts to support the CAP process and to assist the states in addressing provider education gaps and issues, CMS has established the Provider Education PERM Initiative (PEPI). PEPI shall assess the adequacy and/or quality of provider education efforts to determine if the education is adequate or reflective of a weakness in specific areas of knowledge of PERM Program requirements. CMS has established a web page with provider focused information such as:

- ▶ PERM overview for providers
- ▶ Frequently asked questions
- ▶ Samples of documentation request letters
- ▶ A matrix that lists documents most often requested by claim type
- ▶ The list of state PERM liaisons

The PEPI effort to a great extent relies on interaction and feedback from the PERM Stakeholders which include but are not limited to CMS, PERM contractors, states, Regional Offices, and Medicaid and CHIP providers. The website is monitored and updated based on program changes, document updates, and feedback from stakeholders. A PERM Provider email account has been established to address all general PERM inquiries from providers. CMS monitors and informs states of related questions and responses. The PERM RC and State Liaisons assist with questions that may have state specific implications.

State CAPs are reviewed for education opportunities that CMS can support to target large organizations and/or specific provider types. CMS works with states on an individual basis or as a group for example, the PERM Cycle states to develop content and provide telecommunication support.

The PEPI assists the Cycle Managers and the states with the review of correspondence that is intended to inform and educate their providers about PERM and their responsibilities. This review provides support in the verification of the most up to date PERM regulatory requirements and procedures.

### Provider Education PERM Initiative (PEPI) Workgroup

Within the initiative, a collaborative workgroup has been formed as another method of support. Members consist of PERM CAP state liaisons, PERM Review Contractor (RC), state PERM liaisons, and representatives from the Regional Offices. The PEPI focus is:

- ▶ Development of provider focused training and materials
- ▶ CMS/PERM Website review and updating
- ▶ Monitor and respond to PERM provider email inquiries at:  
[PERMProviders@cms.hhs.gov](mailto:PERMProviders@cms.hhs.gov)
- ▶ Support and provide PERM cycle provider education activities
- ▶ Facilitate PEPI workgroup research and development activities that contribute towards building a repository of best practices that all providers in all states can access

Participation is open to all states and Regional Offices. Participants also benefit from discussions of challenges and lessons learned used to develop and update education activities.

### **Provider Education Webinars and Conference Call Sessions**

During each PERM Cycle, several provider education webinars and accompanying conference calls (usually 4-6) are scheduled. They are scheduled in advance of the approximate time frame the RC will begin contacting providers and sending “Initial Request for Documentation” letters. State liaisons are heavily relied on to advertise the calls and develop state specific presentations that could address related corrective actions identified in your state CAPs.

CMS has established a link entitled ‘Provider Education Calls’ which is updated for each cycle to include:

- ▶ Cycle invitation with dates, times, call in number(s) and webinar URLS
- ▶ PERM Provider Overview (video)
- ▶ PERM RC presentation
- ▶ The Electronic Submission of Medical Documentation (esMD) presentation

Webinar/Conference call participants learn from presentations that feature:

- ▶ The PERM process and provider responsibilities during a PERM review
- ▶ Frequent mistakes and best practices
- ▶ The Electronic Submission of Medical Documentation, esMD program, objectives and participation process
- ▶ State specific presentation materials that will be uploaded into the webinars that providers can download

During these sessions, providers have the opportunity to ask questions through the webinar live chat feature, via the PERM Provider email address and, the moderated live question and answer portion of the sessions. The audience is polled on four questions that are designed to show:

- ▶ Awareness of the esMD
- ▶ The states in which they provide services
- ▶ Their provider claim category, and
- ▶ The number of people participating with them

These results are shared with the states as informational tools that can determine outreach success, what questions are being asked by providers and the highest participation levels by provider type. Collaboratively, questions can be added or modified as needs and educational goals are updated.

### **State Systems Workgroup**

The State Systems Workgroup (SSWG) is a collaborative group made up of CMS, the SC, RC, RO and the states to address state system issues. This group works together to determine the

underlying problems and discuss how the issues can be resolved. The State Systems Workgroup call typically occurs prior to the submission of the final CAP so states can include those issues and corrective action within their CAPs. CMS will contact states if an issue is identified and States are welcome to contact CMS at any time if they would like to discuss any program issues.

## PERM Technical Advisory Group (TAG)

The PERM TAG is a forum established to discuss technical and operational issues and to share best practices relating to the PERM Program. The TAG is composed of a combination of the Division of Error Rate Measurement (DERM) Director, the PERM team, state Medicaid Directors, CHIP Directors, and state personnel such as managers, supervisors, and program integrity directors. Meetings are presided over by the committee chairperson(s).

The CMS PERM staff member is the principal contact for the PERM TAG and works with the chair in preparation for each PERM TAG conference call, gathering agenda items, discussing protocol, and work planning issues. Each CMS Region has a TAG representative and membership is normally one to two years. Meetings are quarterly in January, April, July, and October. The TAG website is located at [www.cms.gov/perm](http://www.cms.gov/perm).

The TAG provides a venue for open discussions, policy discussions, and an opportunity for states to offer feedback on PERM issues. The TAG also informs and advises CMS in preparation of guidance and regulations, reviews operational policies, and identifies and resolves issues related to PERM.

## Mini-PERMs

A “Mini-PERM” measurement is a scaled version of PERM designed to identify Medicaid and/or CHIP improper payments. “Mini-PERMs” provide states an opportunity to use federal resources to review Medicaid/CHIP payments made during an off year from PERM or in a way that is out of the scope of PERM. “Mini-PERMs” are state-specific because the state determines aspects such as sample size, universe composition, review procedures, error definitions, etc. “Mini-PERMs” can focus on a smaller sample, a particular component (FFS, managed care, or eligibility), a specific service type, or anything else a state may choose. Many states have expressed the desire to conduct such a review but have not been able to, primarily because of resource constraints. CMS is offering the resources necessary to conduct these measurements. CMS has reviewers, statisticians, and other resources available to assist states in conducting “Mini-PERMs”. CMS aims to make these measurements as flexible and non-burdensome for states as possible and, therefore, the design of the measurement and the CMS resources used are determined by the state.

“Mini-PERM”s would occur during a state’s off years from PERM. Conducting “Mini-PERMs” during off years allows states to look at payments not being reviewed under PERM and prevents the need to coordinate both efforts simultaneously.

Conducting “Mini-PERM” is an opportunity for states to identify improper payments in state-specific areas and to develop mitigation and elimination strategies. “Mini-PERMs” will allow states to develop targeted corrective actions to decrease improper payments made in Medicaid and CHIP. In addition, “Mini-PERMs” are a corrective action strategy to focus on errors or problems identified in the Cycle Summary Findings Report. “Mini-PERMs” are separate from PERM and results will not be reported or released. Findings will not cause a state’s PERM

sample size to go up (or down). In addition, “Mini-PERM” work qualifies for the same federal administrative matching as the normal PERM cycle work. In general, “Mini-PERMs” are a strong program integrity effort without the states expending significant resources.

States interested in conducting a “Mini-PERM” or looking for more information can contact CMS to discuss the focus of the “Mini-PERM” and which CMS resources would be appropriate for the state conducting the measurement.

## CMS Contacts

Cycle Topic	Contact Liaison
<b><i>Cycle 1 FY (12, 15) Cycle Manager, Recoveries</i></b>	Allison Bramlett 410-786-6556 <a href="mailto:Allison.Bramlett@cms.hhs.gov">Allison.Bramlett@cms.hhs.gov</a>
<b><i>Cycle 2 FY (13, 16) Cycle Manager, Recoveries</i></b>	Tracy Smith 410-786-8418 <a href="mailto:Tracy.Smith@cms.hhs.gov">Tracy.Smith@cms.hhs.gov</a>
<b><i>Cycle 3 FY (11, 14) Cycle Manager, Recoveries</i></b>	Wendy Chesser 410-786-8519 <a href="mailto:Wendy.Chesser@cms.hhs.gov">Wendy.Chesser@cms.hhs.gov</a>
<b><i>Provider Education</i></b>	Sarah Leipnik 410-786-3933 <a href="mailto:Sarah.Leipnik@cms.hhs.gov">Sarah.Leipnik@cms.hhs.gov</a>
<b><i>State Systems Workgroup &amp; Mini PERM</i></b>	Tracy Smith 410-786-8418 <a href="mailto:Tracy.Smith@cms.hhs.gov">Tracy.Smith@cms.hhs.gov</a>

CAP State Assignments	CMS PERM State CAP Liaison
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Alabama, Florida, Kansas, Iowa, Kentucky, Missouri, Montana, New Mexico, Oklahoma, South Carolina, South Dakota, Tennessee	Tracy Smith 410-786-8418 <a href="mailto:Tracy.Smith@cms.hhs.gov">Tracy.Smith@cms.hhs.gov</a>
California, Colorado, Idaho, Illinois, Louisiana, Michigan, Nebraska, Nevada, Ohio, Oregon, Texas, Utah, Wisconsin	Nicholas Bonomo 410-786-8942 <a href="mailto:Nicholas.Bonomo@cms.hhs.gov">Nicholas.Bonomo@cms.hhs.gov</a>
Alaska, Arkansas, Delaware, Georgia, Indiana, Maryland, Massachusetts, Minnesota, Mississippi, North Carolina, Rhode Island, Virginia, Washington	Felicia Lane 410-786-5787 <a href="mailto:Felicia.Lane@cms.hhs.gov">Felicia.Lane@cms.hhs.gov</a>

## Review Contractor Contacts – A+ Government Solutions, LLC.

Contract Focus Area	Contact Liaison
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<i>Health Information Management Manager</i>	Albert Key 301-987-1119 <a href="mailto:akey@aplusgov.com">akey@aplusgov.com</a>
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### Statistical Contractor – The Lewin Group

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## Appendix A

### SAMPLE PROVIDER EDUCATION LETTER

Dear State:

With the national implementation of the PERM program to measure improper payment in Medicaid and the Children's Health Insurance Program (CHIP), we recommend that you educate your program providers about the importance of their cooperation and participation in submitting complete medical records timely to support evaluation of the accuracy of claims payments. You can begin educating your providers now even if you are not being reviewed this year. To that end, we have provided draft language below that you may find helpful in your provider outreach efforts, writing a notice for placement in provider newsletters or other announcements such as remittance notices or posting to your state web sites.

Dear Provider:

The Improper Payments Information Act of 2002 directs Federal agency heads, in accordance with the Office of Management and Budget (OMB) guidance, to review annually, programs that are susceptible to significant erroneous payments and report the improper payment estimates to Congress. OMB identified Medicaid and Children's Health Insurance Program (CHIP) as programs at risk for erroneous payments. The Centers for Medicare and Medicaid Services (CMS) will measure the accuracy of Medicaid and CHIP payments made by States for services rendered to recipients through the Payment Error Rate Measurement (PERM) program. CMS uses contractors to measure improper payments in Medicaid and CHIP. Your interactions in the process of collecting medical records for the PERM review will be primarily with our review contractor, who will collect medical policies from the State and medical records from you, either in hardcopy or electronic format.

Medical records are needed to support required medical reviews for PERM so that our review contractor can review the fee-for-service Medicaid and CHIP claims to determine if the claims were correctly paid. If a claim, in which your provider number was identified on the claim to receive reimbursement and is selected in a sample for a service that you rendered to either a Medicaid or CHIP recipient, the CMS contractor will contact you for a copy of the required medical records to support the medical review of the claim. For reviews that require extra information, the contractor will contact you for additional documentation. You will then have 14 calendar days to submit the requested additional documentation.

Understandably, you are concerned with maintaining the privacy of patient information. However, providers are required by Section 1902(a)(27) of the Social Security Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance

and provide CMS, or its contractors, with information regarding any payments claimed by the provider for rendering services. Providing information includes medical records. As for CHIP, section 2107(b)(1) of the Act requires the CHIP State plan to provide assurances to the Secretary that the State will collect and provide to the Secretary any information required to enable the Secretary to monitor program administration and compliance and to evaluate and compare the effectiveness of States' CHIP plans. In addition, the collection and review of protected health information contained in individual-level medical records for payment review purposes **is permissible** by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164. No special patient permission is necessary for the release of records.

In order to obtain medical records for a claim sampled for review, the CMS contractor will contact you to verify the correct name and address information and to determine how you want to receive the request (i.e., facsimile or U.S. mail) for medical records. Once you receive the request for medical records, you must submit the information electronically or in hard copy within 75 calendar days. Please note that it will be the responsibility of the provider who is identified on the claim to receive payment, to ensure that any and all supporting medical records, from any and all provider(s) who rendered a service for which the claim payment under review was requested, is submitted in a timely manner. During this 75-day timeframe, the CMS contractor will follow up to ensure that you submit the documentation before the timeframe has expired. Your State officials may contact you to assist in identifying the required documentation for submission.

It is important that you cooperate with submitting all requested documentations in a timely manner because no response or insufficient documentation will count against the State as an error. Past studies have shown that the largest cause of error in medical reviews is no documentation or insufficient documentation. As such, it is important that information be sent in a timely and complete manner. If you have any questions about this matter, please contact your State PERM contact (**Insert name and Contact Information Here**). Thank you for your support of the PERM program.

## Appendix B

### Differences In FY2013 and FY2016 PERM Cycles

- Six significant changes to Data Processing reviews:
  - OIG LEIE independent search for matches
  - ACA risk based screening requirements for newly enrolled providers after 3/24/11 (including billing, performing and ordering/referring providers)
  - ACA risk based screening requirements for all providers by 3/24/16
  - Fingerprinting and Criminal Background Checks are required to be implemented starting on 8/1/15 for newly enrolled high risk provider types, and fully implemented for all high risk provider types by 6/1/16
  - Recipient Eligibility information needs to be verified from source system
  - HIPAA 5010 transaction standards for electronically filed claims after 7/1/12
- Changes to data processing, medical review, and medical record requests orientations
- Implementation of SMERF 2.0 hosted by A+ Government Solutions, LLC

FY 2013	FY 2016
3 components measured: <ul style="list-style-type: none"> <li>• FFS</li> <li>• Managed Care</li> <li>• Eligibility</li> </ul>	2 components measured: <ul style="list-style-type: none"> <li>• FFS</li> <li>• Managed Care</li> </ul>
FFS Stratification by 10 service types	FFS Stratification by 4 service types and “other” category

	Expansion of Medical Review and Data Processing error codes and qualifiers (reasons for errors)
	Two additional letters sent to providers: <ul style="list-style-type: none"> <li>• Receipt of Insufficient Documentation Letter</li> <li>• Resubmission Letter</li> </ul>
	New medical record request letter format (written in plain language)
	Updated/revised Claim Category Documentation Matrix (which describes the types of documentation needed for each claim type)
DP orientation meetings included PERM overview for each state on an individual basis	Comprehensive RC Educational Webinars will be offered in March/April including data processing, medical review and medical records request processes for all states. Therefore, the time required for DP orientation meetings will be reduced.
DP orientation meetings used to be scheduled for at least 2 days	Individual State DP orientation meetings will be shorter and focus on systems questionnaire, systems review/training for the DP team and gathering necessary documentation
DP orientation meetings used to be primarily on-site	DP orientation meetings will be conducted through conference call/webinar as much as possible (where appropriate)

Systems Questionnaires used to be distributed one month before DP orientation meeting	Systems Questionnaires will be distributed for all states at once to allow adequate time to complete for each system that must be reviewed
Recipient Eligibility information used to be only reviewed in MMIS	Recipient Eligibility information needs to be reviewed in MMIS and verified in the Eligibility source system through direct access, reports or screen prints for every sampled claim for all quarters for FFS and managed care
Issues were identified with States not being prepared for on-site visits when scheduled	New State DP Checklist needs to be completed prior to on-site to confirm that all necessary arrangements have been made.
Verifying Provider information was only required for billing and performing providers	Under ACA requirements, all newly enrolled providers after 3/24/11 (including billing, performing, ordering, referring or prescribing providers) will have to meet new enrollment /risk based screening requirements.
No requirement for OIG LEIE verification checks	OIG LEIE verification checks must be conducted independently by RC
On-site DP review weeks used to average 2-3 weeks per state	On-site DP review visits will range from 2-6 weeks per state depending on sample size and number of systems to review. States are strongly encouraged to consider read-only remote access to your systems for the DP reviewers to minimize the disruption at the state.